Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18 2010 **Physician** QA narch /Medical 4a. Facility Name (If not institution, give stre 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Seasons Hospice Randallstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2X F Yrs. 8/10/1946 63 MD 216-52-8386 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exeminer must be infilled at 1 ☐ Yes 24 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9009 Dogwood Rd. 21244 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ¹¾∑Never Married 2 ☐ Married 1 TYes 2XXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 XNo Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 S.S. Administration Claims Rep 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl Hawk, Sr. Evlyn Meekins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3820 Elm Croft Rd., Cockeysville, MD 21030 Carl Hawk, Jr. -Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State S. Carroll Crematory 3/20/2010 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD 21. Signature of Funeral Sorvice ²² Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 10 23a. Part 1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on sich line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician neumoni /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav 5 ☐ Other (specify) ed by the detached t 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 1 ☐ Yes 2 🗆 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö e Funeral Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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30. Name and address of person who completed caus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HALGAS Physician/ Month 2 RANK 105 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 337 Eagle Hill Road Pasadena Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 16 19 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min Country) 194-34-1996 Yrs. Director 64 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Maryland Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 337 Eagle Hill Road 21122 IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☒ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Electronic Company Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Frank Halqas Helen Nellie Polpar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Halgas 4726 Jewel Drive, Pittsburgh, PA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State March 23 Metro Crematory Inc 4 Donation 5 Other (Specify) 2010 Baltimore, Maryland 21. Signature of Funeral Service Livense 22. Name and Address of Facility ame and Address of Facility Stallings Funeral HOme, P.A 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or compile ations that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final 19 set and Boath System. GEARIGIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. (Discoss or links) Examiner Due to for se's consequence of, Hospital or Attending Physician; The law lequires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year Yes 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has t 24a. Was an autopsy performed' 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ည 1 🗌 Yes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Print)

cause of death (Item 23a) (Type,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Edmund W. Huppman, Sr. 6:00PM 2010 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore County Baltimore Heritage Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year)
Dec. 14,1929 Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours **X**XM 2□ F Yrs 80 Dec. Director 214-26-4803 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examination use to multifued at 1 □Yes 2 No Director Baltimore Baltimore County Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 USA 3 Fullerton Heights Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★XYes 2 □ No If Yes, Give Year or Dates: 1948~52 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√2No Specify. Specify: White þ 3X Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Policeman Baltimore City Police 12 yrs. yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Belt Edmund Huppman ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Fullerton Heights Avenue Baltimore, Md. 21236 Jerry G. Huppman (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 3~25~2010 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral 7401 Belair Rd. 21. Signature of Funeral Service Licensee Home Baltimore, -J. Lassehn Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last ue to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 IDOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Watural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed and the burial-trar Division of Vital Records, P.O. Box 68760, attending physician use as for the been signed by t should be detach page 2 should certificate has funeral director. this death. filled in by

should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Hospital or Attending within 24 hours after deatl To the Funeral Director:

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

29a. Certifier

(Check only one)

29b. Signature and title

en who completed seuse di death, (Item 33a) (Type Plipt) 32. Registrar's Signature

m0

1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RITCHIE

29d. Date signed (Month, Day, Year)

MARCE 22, 2010

HIGHWAY, BACTIMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend 19a per Fh g901 3/24/10 TT

State of Maryland / Department of Health and Mental Hygiene 2 | | | 09004 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Pay 2010 Physician/ 4:25 Harris Ам Paula Ann Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fox Chase Rehabilitation and Nursing Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min 1 □ M 2 🖾 F Months Days Hours 7 /187 1944 Country) DC 65 578-56-1391 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Washington 1 X Yes 2 No DC 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 20011 USA 4508 New Hampshire Ave. permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items: any jairy or other traumatic event, the Medical Examiner must once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Payroll Clerk years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Dorothy M. Brown Oliver P. Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
43 Theodore St Apt# 2 Dorchester, MA 02124 19a. Informant's Name/Relationship (Type, Print) Margaret Mattox/ friend cousin 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other placel 1 X Burial 2 Cremation 3 Removal from State 3-29-2010 Silver Spring, MD Gate of 4 Donation 5 Other (Specify) Heaven Cem. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshalls Funeral Home M00977 4217 9th ST NW Washington, DC 20011 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ Cardiomyopathy disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 10 yrs. Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hypertension nding physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Chronic Kidney Disease Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Coronary Artery Disease 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🛅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 - No 2 🗆 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 2₹ No 4 🖾 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier R096053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 Shady Grove Rd. Rockville, MD 20850 Ravi Passi, MD 31. Date filed (Month, Day, Year) NAR 24 32. Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

barker

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend Item 29a per dyr g901 3-24-10 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death SDay 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Year 50 AM **Physician** 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner illa VILLE rederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign South Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Year) Months Min 1 ☐ M 2 😿 F 7.48-777 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it with Marches Expr. it are used to confide 1 XYes 2 □ No **Funeral Directo** more 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify þ 3 XWidowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) eacher 18. Mother's Name (First, Middle, Maiden Surnan 17. Father's Name (First, Middle, Last) a ပ 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brooks SON Martora Baltimore Hamlin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Laurens, 3-30-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Vaughn
C. (ZIZZ9 Mational DILLERE Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia 21 emer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi g pertensio the attending physician and Due to (o) as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2.⊠No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Yes 2 🔼 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural □ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one nurse practioner and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

			Amend 19b & 22	ype or Print in Per Fh G90 State of Maryla	Black Indeli 1 3/24/10 nd / Departm	i ble Ink. nent of H	Ensure A ealth and N	II Copies Jental Hy	Are Legible	n nonns
	Physicia		For State Registrar 1. Decedent's Name (First, Middle, Last,	aphries	Certific	cate of L	Death	2. Date of De Month	ath Day Yea	3. Time of Death /: 45 A M
0	/Medic Examina Funeral Director	er '	2810 Winchester Social Security Number 6. Se	Street and number)	rs. last birthday)	City, Town, or Inder 1 Year Inths Days	Location of Death 10 re If Under 24 Hrs. Hours Min.		th Year) 9. E	Birthplace (State or Foreign Country)
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. It health and Mental Hyglene. It is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is the dignifical experience of the filed in the following the		Jsual Residence of Decedent 10a. State 10b. County		City, Town or Location Baltimor					10d. Inside City Limits 1 Yes 2 □ No
4		eral Di	10e. Street and Number 28/0 Winchester 11. Marital Status	Street 12. Was Decedent Ever in		f. Zip Code 212 Decedent of Hi	ispanic Origin? (S n, Mexican, Puert	pecify Yes or No	10g. Citizen of What USA 14. Race - A	merican Indian,
0036		d by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 📈 Divorced	Armed Forces? 1	1 □Y	es 2 No	Specify:	o Rican, etc.)	Specify:	Black
Maryland 21215-0036	ed within 72 n ygiene. ner than "natu it, the Medica	Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation (e completed) College (1-4or 5+)	16a. Decedent's (Give kind of life, DO N	of work done o OT use retired	during most of word		RaHinore	Cty Schools
aryland	permit. Pages 1 and 2 should be filed bepartment of Health and Mental Hygi Important; If Item 27 is marked other any injury or other traumatic event, 100ce.	To Be	17. Father's Name (First, Middle, Last) Stillman 0 (1) 19a Informant's Name/Relationship (7)	Butler iyoe. Print)	19b. Mailing Ad	dress (Street	Ruby	Lee 1	Pasco per, City or Town, Stat	e, Zip Code) 21206
ຜົ.			Toc. T. Malloy (1) 20a. Method of Disposition 1 Burial 2 Cremation 3	_	5825 for Place of Disposition cemetery, cremator	y or other plac	1	le (1000)	20c. Location - City Both More	1974/14/19 21212 or Town, State Yo Maryland
Baltin			4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Prior 6 Licens	10/553	ya. Nai	me and Address hn C.	ss of acility Greene F	S. 13	905 York M	Clad 21212 aryand 21216
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aA	eath. Do not entected	C P	MCRE7	ATIC	CANCER	Approximate Interval Between Onset and Death
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	lical Examiner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons C. Due to (or as a cons d						
AVV OF		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time - 9 Unknown	etal death 3 Ect	opic pregnanc ner (specify) _	y		23d. Date of Month	,
Hands, P		ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.						te to the cause of death? Probably 4 Unknown	
Hicia ital Recor		Completed						per 1 □ Yes	formed? deat	e autopsy findings available r to completion of cause of th? Yes 2 \sumbox No
of V		: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year	≥ ☐ ER/Outpatient 3		4 Li Nursing r	Home 5 Res	sidence 6 Other (Specify)
Division		Certification:	27. Manner of Death 1 Hatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred						or Rural Route Number,	
	Hospital 24 hours a Funeral C etely filled	Medical Ce	29a. Certifier 1 ← Certifying Ph (Check only one)	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death occinination and/or investi	curred at the ti igation, in my o	ime, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s) and mann e, date and place, and	er as stated. due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	6 445		29c. Licens	se number		29d. Date signed (A	Month, Day, Year)
, h			30. Name and address of person who	completed cause of death (Item 23a) (Type, Prin	2 86	BAL	M MOM		21702
1	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 4 20	32. Registrar's Si	ignature &					_

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year Physician/ March 20, 2:30 P M Mildred E. Hoey Medical 4a. Facilify Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Taneytown 8 Commerce Street Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth 7. Age (In yrs, last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F 1271271935 Maryland Director 213-30-4787 74 Usual Residence of Decedent show er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Taneytown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 8 Commerce Street 21787 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No White Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 2 should be filed with h and Mental Hygien 7 is marked other th Waitress Retail Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lucinda Cole Robert Lawhon injury or other traumatic 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2835 Hollins Ferry Road, Baltimore, Maryland 21230 John M. Hoey / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Bayview Crematory 3/23/2010 Baltimore, Maryland 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ CHRONIC OBSTRUCTURE PULMONIKY 10 years resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Que to (or as a consequence of, the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? After Certificate: 28d. Describe how injury occurred injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident М Investigation within 24 hours after death
To the Funeral Director: ,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕝 🧲 critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31660 3/23/2010 trana Jalano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Homes K GAWW TH 2011 STONER Avenue mesmin ster maryland +115) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Jacker

4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 6, 2010 HARRY ALLEN JOHNSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1637 PLEASANTVILLE DR. **GLEN BURNIE** ANNE ARUNDEL 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours MD JULY 13, 1929 80 215.24.8617 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 Is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examination and the notified a 1 ☐Yes 2 ☐No Director GLEN BURNIE ANNE ARUNDEL MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 21061 1637 PLEASANTVILLE DR. 12. Was Decedent Ever in U.S.
Armed Forces?
↑ Yes 2 No
If Yes, Give
Year or Dates: 1946-52 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married 1 □Yes XX No altimore, Maryland 21215-0036 Specify \$ WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) it of Health and Mental Hygiene. Elementary/Secondary (0-12) GENERAL MOTORS PLANT AUDITOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HELEN BUDDENBOHN WILLIAM GEORGE JOHNSON, SR ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1637 PLEASANTVILLE DR. GLEN BURNIE, MD 21061 WIFE EMMA L. JOHNSON other Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State ö Department of Important: If any Injury or once. BALTIMORE MD MARCH 10, 2010 BAYVIEW CREMATORY INC 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Vr. Funeral Service Licens FINK FUNERAL HOME, P.A. wegger 426 CRAIN HWY SW GLEN BURNIE, MD 21061 K. CRECORY FINK M01148 23a. Part 1 Enter the disease, or cc p cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List on o e cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗍 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has treetor, page 2 s autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☑ No this certific al director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide LECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical-Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature ursel 31. Date filed (Month, Day, Year) State Registrar

10-02308 Michael Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1057 hrs **Medical Examiner** Jones March 22, 2010 Michael 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (if not institution, give street and number) Baltimore N/A 3601 Fords Lane, Apartment 503 If Under 1 Year If Under 24Hrs, 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Country)MD Months Days Hours Director 217-78-6915 06/12/1959 50 1X M 2 F Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. Count 1 X Yes 2 No Baltimore s 23a or 28a-f shov e notified at once. or 28a-f show MD N/A hours after death with the Maryland rector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Apt. 503 21215 3601 Fords Lane 14 Race - American Indian, Black Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status or items Armed Forces? 1 Never Married 2 X No Yes White 1 Yes 2 X No specify: Specify: 4 X Divorced If Yes, Give Year 3 Widowed marked other than "natural", δ. 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than " N/A Dependant Com 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Spencer Henry Jones Kathryn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9334 Ravenridge Road, Baltimore, MD 21234 Deborah Pecora, Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place X Burial 2 Cremation 3 Removal from State 03/26/2010 Baltimore, MD Gardens of Faith 4 Donation 5 Other Specify. Leoanrd J. Ruck, Inc. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 Uyarana 7 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Medica) Death a Intracranial Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b Hypertensive Cardiovascular Disease Sequentially list conditions, Due to (or as a consequence of) If any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ηνsician/Medical trending physician a UNPENDED AMENDED so the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown certificate has been signed by the att ector, page 2 should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ≥ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed death? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification 1 🗸 Natural 1 Yes 2 No Director: Pending 24 hours after death. Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 23, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCME

ORIGINAL

		For	State of Ma	aryland / Dep			Mental Hyg	giene	00010
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within 72 hours after death with the Maryland giene. then "natural", or items 23a or 28a-f she than "natural", or items 24a or 28a-f she, the Medical Examiner must be notified at	ral D	10e. Street and Number	arkway		10f. Zip Code	21702		10g. Citizen of What Co	*
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D ~ ° ±		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cr	matory or other plac	ce)	Date	20c. Location - City or	
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or Atte fter des irrector n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	be 280 Place of Injur	ry - At home, farm, s (Specify)	reet, factory, office		28f. Location (S City or Town	treet and Number or Run, State)	ral Route Number,
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Phy	ysician: To the best of n	ny knowledge, death	occured at the time	, date and place, ar	nd due to the cau	ise(s) and manner as st	ated.
the Ho hin 24 l the Fu npletec	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	niner: On the basis of ex rse Practioner: To the b	amination and/arians	otication is an aniel	an death againmed a	A Abra Alman I aka ma	and allowed and allow to the	cause(s) and manner stated.
To wit		29b. Signatule and the of certifier			29c. Licens	6 LLL 3		29d. Date signed (Mont	
		30. Name and address of person who		eath (Item 23a) (Type,	death occurred at the	Divis	012	: # 12.2	1
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Registra	ar	MAR 2	4 2010 Negister	neur B.	Maria				

OHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PARCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In vrs. last birthday)
Yrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Director Usual Residence of Decedent 10c. City, Town or Location Centon is 1 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits Directo entervi 1 Yes 2 No 10f. Zip Code 216/ 10e. Street and Numb 10g. Citizen of What Country? Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ogday (0-12) College (1-4 or 5+) echanic Be ather's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) ည (QuFFMQn Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code Son lohnson to MD &1230 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State 1 🔲 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Funeral Service Lice to.MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ Due to or as consequence of): cancer disease or condition Medical resulting in death) **Examiner** brai 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of eral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an safter death.

Director: After this certificate has autopsy 2 No 1 🗌 Yes Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗆 Yes 2 Al No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) hospice house 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🔀 Natural 5 Pending 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours: To the Funeral I the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Menery 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARZOH VIRGINIA R KAVALESKY 0520 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE JOHNS HOPKINS BAYLLOW MEDICAL CONTER Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 4 / 23 / 38 6. Sex Birthplace (State or Foreign Country) Funeral Hours 413-54-6165 1 □ M 2**X** F Days **Director** VA Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State MD 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3002 Hudson Street Funeral 21224 USA items "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛛 No If Yes, Give 1 Never Married 2XXMarried þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Bakery H and S Bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Mullins Artha Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Micheal Kavalesky (Husband 3002 Hudson St., Baltimore, MD, 21224 item 20a. Method of Disposition

1XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 3/26/10 Pound , VA John H. Mullins 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility P.O. Box 331 21. Signature of Funeral Syrv ce Lenses Baker F.H. Pound, VA. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ RESPIRATOR FALLURE
Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner 2 WEEKS COPD EXACERBATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 7.No
9 Unknown Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? death. 1 Yes 2 No Investigation 6 Could not be within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29b. Signature and title of certifier 29c. License number MARCH 22, 2010 RES COO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVE, BALTIMORE, MD 21224 WANSOM, MD TANY APCRN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

			Please 1	ype or Print in Black Inc			_			
			For State	State of Maryland / Depa	artment of I <i>rtificate of</i>			09013		
			Registrar 1. Decedent's Name (First, Middle, Last)		imodic or	2. Date of		3. Time of Death		
	Physicia /Medic			John A. Kamasins	ski	Month	19 a o/			
1	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death 4c. County of Death					
			5. Social Security Number 6. Se	(C 1105 p + A 7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. 8. Date of	Balti Balti	molC rthplace (State or Foreign		
	Funeral Director			Yrs. 60	Months Days	Hours Min. (Month,	Day, Year)	aryland		
	pu ,	To Be Completed by Funeral Director	Usual Residence of Decedent					10d. Inside City Limits		
21215-0036	show		10a. State 10b. County 10b. Roll+i	10c. City, Town or Lo				1 ☐ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
	the N 28a-i		MD Baltin	nore	Nott:	ingham	10g. Citizen of What C			
	h with		17 Lark Meadow	Court	2	21236	United St	ates		
	ems 2		11. Marital Status	12. Was Decedent Ever in U.S. 13. \ Armed Forces?	Vas Decedent of I	Hispanic Origin? (Specify Yes or ean, Mexican, Puerto Rican, etc.)	No- 14. Race - Am Black, Whi			
	, or it		1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 XNo If Yes, Give	I∐Yes 2∏XNo		Specify:	Specify:		
	hour stural		15. Decedent's Edu	Year or Dates: cation 16a. Dece	dent's Usual Occu	pation	16b. Kind of Business	White s/Industry		
215	hin 72 e. an "na		(Specify only highest grad	e completed) i (Give	kind of work done OO NOT use retire	during most of working d)	71	·		
	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at		12 Years	1 Year	Repair			otors Corp.		
Maryland	ntal H ed oth		17. Father's Name (First, Middle, Last) Marion Kamasi	a clai		18. Mother's Name (First, Mid Gertrude Czu				
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 23a-f show aumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship (7)		a Address (Street	t and Number or Rural Route Nu		Zip Code)		
	aith a aith a 27 is er trau		Mrs. Phyllis L.	· '		low Court Balt				
Baltimore,	es 1 a of He fitem rrothe		20a. Method of Disposition	20b. Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce) Date	20c. Location - City o	r Town, State		
Ë	Pag tment tant: I		1⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Ht of Mary Cem 3/23/2010 Baltimore, Maryland							
Ball	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic enone.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.							
			23a, Par 1. Enter the disease or compl	instings that assumed the death. Do not out		e Ave. Dundalk.		21222 Approximate		
	Physician		Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Deatl							
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of): Segmentially list conditions b. Line Foundation							
	Examiner	_								
	ted ssit	xamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				Î		
<u>,</u>	executed in and ial-transit	Exar	that initiated events resulting in death) Last C. Repair (E) Due to (or as a consequence of):							
68760,	ficate be ex physician s the burial			.						
89	ertifica ing ph	by Physician/Medical	IF FEMALE:							
Вох	eath certific attending p for use as		23b. Was decedent pregnant in the past 12 months?		Ectopic pregnan	су	23d. Date of d Month	elivery Day Year		
Ö	at the de by the a tached t		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown						
ď.	g g ‡		Part II. Other significant conditions co	ntributing to death but not resulting in the ur	nderlying cause gi	ven in Part I. 23e. D	id tobacco use contribute	to the cause of death?		
ords	w requires been sign should be									
ecc	law renas be	Completed				24a. W	/as an 24b. Were a	autopsy findings available completion of cause of		
Vital Records,	Ician: The L certificate ha ector, page	Certification: To Be Con					erformed? death?	s 2 🗆 No		
Vit			25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatier	. a E soa Oti	26. Place of Death (Check on				
			27. Manner of Death	28a. Date of Injury 28b. Time of	IL 3 L DOA	4 Li Nursing Home 5 Li H	Residence 6 Other (Specify) cribe how injury occurred			
Division	Attending ir death. ector: Afte by the fune		Natural 5 ☐ Pending investigation	(Month, Day, Year) Injury		Yes 2 □No				
ivis	or Atta	rtific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attenc within 24 hours after deatt To the Funeral Director: completely filled in by the									
	e Hos 124 h e Fun eletely	edical		ner: On the basis of examination and/or in and manner stated.						
	To the h within 24 To the F complete	Me	29b. Signature and title of dertifier		29c. Licen		29d. Date signed (Mor			
			MA	MSIUADE, MA		D0064322	3/19/10			
M	$\sqrt{}$		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type,	Print)	<u> </u>		2/337		
V	Sta	te	31. Date filed (Month, Day, Year)	VCS LCCCS YCC 32. registrar's Signature	o Fran	Min squale	Drive Balti	Mar, MD		
	Registr		MAR 24 20	ompleted cause of death (Item 23a) (Type, VCS) (CS 900) 32. pugistrars Signature	arked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Month Year **Physician** 4:35 P M March 19, <u>Edward L. Kestler, Jr.</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel FutureCare of the Chesapeake Arnold Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 □ F Yrs. Director 92 8/25/17 Maryland 213-05-3059 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director MD Ocean City Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21842 USA 9100 E. Biscayne Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WW II 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It. III. Elementary/Secondary (0-12) College (1-4or 5+) 12 Firefighter Balto. City Fire Dept 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward L. Kestler, Sr. Thomas Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7413 Merrimusic Circle Severn, Md. 21144 Edward J. Kestler / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemeterv 3/23/10 Baltimore, Md. 21. Signature of Funeral Service Licen 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Md. 21229 - (4 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** cancer /Medical nsequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? Ye ar 5 ☐ Other (specify) P.O. 1 ☐Yes 2 ☐ No the 9 Unknown signed by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown peen s page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☑ No certificate 2 □ No Division of Vital 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this c 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 29a. Certifier 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature title of certifie 50725

5 V

NAR 24 2010 Annual Signature

Name and address of parson who completed cause of death (Item 23a) (Type, Print)

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Registrar

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nellie 7:40 pM Keller March 7.010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Javers 45 5. Social Security Number Mercical Center wolf Maryland If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Hours (Month, Day, Year) Country) Director 216-22-4802 MD Aug 9, 1925 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4825 Bonnie Branch Rd 21043 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceue...
Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify Specify 3 Widowed 4 Divorced 15. Decedent's Education . Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 75 Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) luknown Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nathan J. Cavey Margaret E. Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond L. Keller Spouse 4825 Bonnie Branch Rd. Ellicott City. Baltimore, MD 21043 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) awn Memorial Gardons 22. Name and Address of Facility Mar 13, 2010 Marriottsville, Maryland Slack Funeral Home, P.A. 23a. Part 1. Soter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician ubdural emetom disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Froke Sequentially list conditions Examine Due to (or as a consequence on ii any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMIN the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death cate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? certificate 2 🗆 No ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 X Yes Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred ☐ Natural

■ Naccident 5 Pending Slipped o 2/2010 4,00 aM within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 X No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 12, City or Town, State) 4825 Benne Brench determined Home Ellicott City, MA 21043 To the Hospital | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 5010 DP8551 1arch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Floor Pulmonain, 1105 Paca 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 22.2010 9:25A KAISS JAMES **EDWARD** Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min March 2,1917 1**X** M 2 □ F 93 MaryTand 212-34-5938 Yrs **Director** Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 XXYes 2 No Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5926 Glenkirk Road 21239 USA 12. Was Decedent Ever in U.S. Armed Forces?

12. Was Decedent Ever in U.S. Armed Forces?

13. Was Decedent Ever in U.S. Was Decedent Ever in U.S. Armed Forces Proceedings of the U.S. Armed Forces 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify:White 1 ☐ Yes XX No Specify. If Yes, Give Year or Dates 3 XXWidowed 4 □ Divorced "natural" the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Clerk Federal Government 12 should be filed wii lith and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Louis Henry Kaiss Sarah Elizabeth Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau DTR 5926 Glenkirk Road Baltimore, Maryland 21239 Susan H Kaiss Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley Mem Gardens Mar 26,2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FaMirtchell-Wiedefeld Funeral Home Inc gnature of Funeral Service Ligensee 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Accident embrouas alar disease or condition lays Medical resulting in death) Due to (or as a consequence of) **Examiner** Coronwy Sequentially list conditions, Physician/Medical Examiner nonsquence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic atrial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Denestia 24a. Was an After this certificate has autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No ☐ Yes Hospital or Attending Physician: ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State To the Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CRNP R149194 March 22 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Charles St Tauson, MD 21204 6701 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roi Laurence Kasten March 2010 9:55 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore 8. Date of Birth Sept 29, 1942 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Hours Months 219-38-1971 Mary Land 67 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Exaπiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1601 S. Rolling Rd 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Specify: White 1 ☐ Yes 2 ₺ No Specify: If Yes, Give Year or Dates 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Rusiness Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) electrcian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lance L. Kasten Mary Ann Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Kasten/son 6000 Healey Farm Rd; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses ^{22.}ទំបានជាម^AAnatiamy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ 2915 Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and -transit Exam The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy perform Yes 1 🗌 Yes] No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

6701

on, will

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20 Day 2010 Kazimiera Karalius 11:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 914 Masefield Road Edmondson Heights Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) 06/13/1935 1 ☐ M 2**X** F Lithuania Director 334–28–4560 74 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No Edmondson Heights Maryland Baltimore 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 914 Masefield Road 21207 United States items ; hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kazimieras Kuzas Alexandra (Unknown) permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Algirdas Karalius - Son 205 Neuse Harbor Blvd New Bern, North Carolina 28560 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory | 03/23/2010 Glen Burnie, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 5311 Fdmondson Avenue Baltimore, Maryland 21229 23. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MetresTATIL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death Unknown sate has been signed by the page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\overline{\text{X}}\) Residence \(6 \) Other (Specify) 1 🗌 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral dir 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatura and title of certifier MArch 22, 2010 M 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 45 Nichal MIL 31. Date filed (Month, Day, Year) Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death broch ! Physician/ 10:31 PM eartoss 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Iniversity of Marylan d Medical Center Homore If Unde If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months Days Hours Min OCT. 14, 1946 1 🗆 M 2 🖫 F Director 63 212-50-6621 NY Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at any injury or other traumatic event, the M-dical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 TWIN WILLOW CT. APT 102 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ THELMA DUNGESS DANIEL H. CEARFOSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 TWIN WILLOW CT. APT 102 OWINGS MILLS, MD 21117 KENNETH KONE, JR.-HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
GARDENS OF FAITH 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 3/19/10 BALTIMORE, MD 4 Donation 5 Other (Specify) MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licer 22. Name and Address of Facility 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final trunal ,⊬hysician/ disease or condition SEPS/5 - 2 weeks Medical resulting in death) Examiner 1-2 Necks Bacterial sepsis Sequentially list conditions, Examiner if any, leading to immediate
Cause (Disease or linjury Due to (or as a conse uence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) the detached 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an r this certificate has eral director, page 2 death? 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2) မ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu М 1 Yes 2 No Investigation 6 Could not be 3 ∐ Suiciae 4 □ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner To the Seat of my knowledge, deeth scrowed at the time, date and place, and due to the newsels) and manner as street 29b. Signature and the of certifier 29c. License number

3/

State

Registrar

Marie

31. Date filed (Month, Day, Year)

Chieripy of Mayland Medical Centr, 22 S. Grane S. Baltimore MD 21201

Posident Physician

32. Registrar's Signature

knews

dress of person who completed cause of death (frem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical Iown, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner eason **Funeral** Months Hours Min. 1 □ M 2 🕱 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h County ral", or items 23a or 28a-f show 1 XYes 2 □ No Funeral Director TIMOre 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?
1 []Yes 2 []No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: þ lack 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) + 18. Mother's Name (First, Middle, Maiden Sur 17. Father's Name (First, Middle, Last) Be ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number Route Number, City or Town, State, Zip Code) 5 tacey E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee aug Nationa 5151 Baltimore Approximate Interval Between Onset and Death 23a. Part 1. Enter of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) pital: 1 Inpane.

28a. Date of Injury
(Montby Day, Year) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Sother (Spe Certification: To 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 □ Yes 2 🗆 No after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

*mo 693*32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 2010 P^{M} JOSEPH LAWRENCE 4:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CALVERT CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK if Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Formal JAN 15, 1920 PENNSYLVANIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Days 1 ₹ M 2 □ F 213-26-1611 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2√☐ No MD. ST. MARYS CHARLOTTE HALL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 29449 CHARLOTTE HALL ROAD 20622 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Alyes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 9TH WEIGH MASTER STEEL COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STEVE LORINCE ANNA SAXON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 JOPLIN STREET, BALTIMORE, MARYLAND RUTH M. LAWRENCE/WIFE 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 3/18/2010 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part 1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an 1 🗆 Yes 2 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No

Examiner requires that the death certificate be executed and burial-trai Box 68760. attending physician the as nse ō signed by the a P.O. Records. peen has page 5 certificate Division of Vital Physician: director After this

Hospital or Attending

death.

24 hours after death Funeral Director:

within 2 the

Examine Physician/Medical þ Completed Be P

Medical

29a. Certifier (Check only one)

31. Date filed (Month.

funeral in by the filled i

Physician

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Exercity at most be notified at

Director

Funeral

₫

Completed

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2

death with the Maryland

within 72 hours after

I Hygiene, other than "

permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If item 27 Is marked other any injury or other traumatic event, III

Physician /Medical

Baltimore, Maryland 21215-0036

/Medical

1 ☐Yes 2 ☐No 9 Unknown 25. Was case referred to medical examiner? 1 Tyes 27. Manner of Death Certification: Natural 2 Accident investigation 6 Could not be determined 3 Suicide 4 Homicide

and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town; State)

Name and address of person who completed cause of death (Item 23a) (Type, Print) Janos Mathur

110 Huspitalien 32. Regis rar's Signature

Ste. 305 Prince Frederick, mo 20678

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STER Day Month MANNING JK 10:10 DM 1arch 20 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 13a Baltimore Hospitalo timore 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 249-96-2879 1 M 2 - F 54 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6504 ARMSTrong AVE. 21215 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Be Completed by 1 ☐ Yes 2 ☑ No If Yes, Give 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) JANITON MAINIENANCE ルスカルルタ シル Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MANNING SK SAddie EGGETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARAH MANNING 6504 Armstrong Ave 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🛱 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place, 3-27-10 RidgE CEM BAlto. Druid 4 Donation 5 Other (Specify) 22 Name and Address of Facility
PARKET FUNETAL HOME BALTO. Md. 21229
3512 Frederick AVE. BALTO. Md. 21229 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ₽nysician/ Acute Mrocardial disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate Yes completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 👿 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred 1 M Natural injury work?
1 ☐ Yes 2 ☐ No 5 Pending s after death. 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) no completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

ueira MD. 2435West Belvedore Avenue Baltimore Md. 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Gloria M. Mitchell March 17 2010 11:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Charlestown Care Center Catonsville Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕱 F Months Davs Hours Min. Director 7/7/25 215-14- 8303 84 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shore Examining the rectified of 1 ☐ Yes 2 No Director MD Baltimore <u>Catonsville</u> 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 707 Maiden Choice Lane Completed by Funeral 21228 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 ₩Widowed 4 Divorced "natura!", White Mudical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) dother than " Elementary/Secondary (0-12) College (1-4or 5+) Clerical Verizon ?7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William James Rictor Pauline India Foster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 1712 Amberly Court South Marriottsville, Md. 21104 Gloria Jean Berger / Daughter item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any Injury or of once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 3/22/10 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rear disease or condition resulting in death) arabral vascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl 2 No 2 **Z** No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation nours after death.

neral Director: Af
y filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Pate filed (Month, Day,

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09024 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month o3 Physician/ JAMES SHEA MALONE 14:48 M 2010 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 4.1<u>933</u> 1 X M 2 □ F Months Days Hours 76 215-30-3314 Maryland Director Usual Residence of Decedent 10h County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland Carroll Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5718 Oklahoma Road 21784 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 XXYes 2 □ No 1953If Yes, Give 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: White Specify: 1955 Completed 3 Widowed 4 Divorced Year or Dates it of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company 12th Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James S. Malone, Sr. Dorothy Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Rosemary A. Malone 5718 Oklahoma Road Sykesville, MD 21784 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20b. Place of Disposition (Name of cemetery, crematory of other place)

South Carroll Crematory 3/23/10 1 ☐ Burial 2xxxCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD Burrier-Queen Funeral Home & Crematory, I 1212 W. Old Liberty Road Sykesville, MD 21. Signatur Funeral Service Ligensee nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Imm diat - Cause (Final dise se - condition resulting in death) Onset and Death Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ISCHMIC HEART DISEASE No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The 24 hours after death. 1 Tes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **X**No Other: မ 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 Natural Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🛮 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P 24346 MARCH 22, 2010 has

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

MAR 2 4 2010

32. Registrar's Signature

A space

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTOPHER R. KOUTZ

ORIGINAL

22 SOUTH GARENEST

21210

BATIMONE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09025 State of Maryland / Department of Health and Mental Hygiene 2 1 | 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3/17/2010 Physician/ Barbara Sue Mallory 17:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospital Center Carrol1 Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funerai 1 □ M 2 🖾 F Months Davs Hours 772471945 Director 219-42-1358 64 PA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Me Ital Examiner must be notified at 10a. State 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 🗌 Yes 2 🔀 No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 810 Deer Park Rd. 21157 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2★XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Housekeeper Fairhaven Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vestal Yelton Carrie Lee Yelton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pam Taylor/Daughter 503 Goldenrod Terrace, Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 3/22/2010 Sykesville, MD 21. Signature f Funeral Service Ligense ²²Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. P rt 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Imm ediate Cause (Final dispase of condition resulting in death) Onset and Death Physician. Medical Due to (or as a consequence in Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner signed by the attending physician and deed be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated event resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ieral Director: After this certificate has been sifiled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at iniury Natural 5 Pendina 1 Yes 2 No Accident Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29b. Signature and title of certify 29d. Date signed (Month, Day, Year) 17 3 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, MD 21157 200 Memorial Ave. Ajay Behari 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State MAR 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d Maryland / Department of Health and Mental Hygiene [] | [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 2010 Frank Moss РМ 2:04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 811 N. Central Avenue Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Jan 8, 1926 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex Days Months Hours Mary Tand 219-12-6606 1**∑**M 2□ F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ty⊡Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21201 811 N. Central Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: black 1 ☐ Yes 2 🎇 No Specify: Specify: **'**43**-**45 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) union representative sanitation dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rueben Moss Lillie Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle McLaughlin /granddaughter 811 N. Central Avenue Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☑ Other (Specify) 21. Signature Eun Defy Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) cute wack Due to (or as a consequence of): ementio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence offic Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Evertment be notified at once.

Baltimore, Maryland 21215-0036

Examiner sician and burial-trans Physician/Medical the as for use signed | Be Completed by page 2 should funeral director, Medical Certification: To

Physiclan; The law requires that the death certificate be executed

has

certificate

After this

within 24 hours after death.

To the Funeral Director: A

filled in by the

completely

or Attending

Hospital

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Death 1 Natural
2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 ☐ Could not be determined

MAR 24 2010

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28d. Describe how injury occurred

(Check only one)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1000 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 4a State of Maryland, 63/24/2010 of Health and Mental Hygiene ? Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6 120 PM Medical 4a. Facility Name (if not institution, give street and number)

2046 Braddish Avenue Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** N/A Joseph Richey Hospice, Inc. 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 🗆 M 2 🖵 F Hours (Month, Day, Year) Director 212-26-7266 So Carolina Feb 28, 1918 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2046 Braddish Avenue 21216 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify. Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **Private Homes** Housekeeper 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of :. Page 1 and 2 should be fil tment of Health and Mental tant: If item 27 is marked o Liza Woods John Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other t 2046 Braddish Avenue Baltimore, Maryland 21216 Rosalind Kearney Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/09/10 Lansdowne, Maryland Mt. Zion Cemetery Sig ture of Free eral Service Licen 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 2

1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between neart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ,⊱hysician∉ disease or condition resulting in death) TNEVE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deelached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen dehy diatron 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , has page 2 autopsy performe this certificate 2 🗆 No 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. eted 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

(3)

32

Registrar
DHMH 17 Rev 7/2009

31. Date filed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, per FH G902 4/13/10 TT

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03^{Month} 20ÎÖ 22 2:55 PM Lillie Grace Matthews Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Liberty Heights Rehab. Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖔 F 04 14 1925 Country Director 246-24-4896 N.C. 84 Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director XXYes 2 \ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 1007 Marlau Drive U S Α "natural", or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Specify: 3

▼ Widowed 4 □ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) <u>12th grade</u> <u>2yrs</u> <u>Cosmotologist</u> Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charlie Crudup Lillie Cross other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niece Shirley Kelly-Daughter Marlau Drive, Baltimore, Md 21212 007 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury 3/27/2010 Arbutus, rbutus Memorial . Signature of Funeral Service Licensee 22. Name and Address of Facility March West F/H Balto, MD 21215 4300 Wabash Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Dan a Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsequence of attending physician and for use as the burial-transit equires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ tive Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No ed by the a 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. e has t een signed ge 2 snould be det 23e. Did tobacco use contribute to the cause of death? Completed by diseas (mee) 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician; Tie law within 24 hours after death.

To the Funeral Director: After this certifica e has the completed filled in by the funeral director, poge 2 s autopsy performed? Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 St. A. AHMED N 821 Eulau

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2010 Philip Martin March 06:33 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7922 Royal Mint Place Pasadena Anne Arundel 8. Date of Birth (Month, Day, Year) Jan. 06 1933 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 😡 M 2 🗆 F Months Davs Hours 510-30-4516 Director 77 Usual Residence of Decedent show 10a, State 10b. County 10c. City. Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 🛣 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 7922 Royal Mint Place 21122 permit. Page 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. the Martical Evantinar 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Director of Data Processing State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Philip Martin Fanny Ringer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7922 Royal Mint Place, Pasadena, MD 21122 Sharon Martin Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State March 23 Maryland Veterans Cen Crownsville, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 23a. Par 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death charan PIROMNEN Physician/ disease or condition Medical resulting in death) Due to r as a consequence of) Examiner NEW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page perform 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Funeral Director: After the eted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 XNatural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

DHMH 17 Rev 7/2009

State

Registrar

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29b. Signature and title of o

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hru

MAR 2 4 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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3, 22, 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0:/0AM 2010 LON /Medical City, Town, or Location of Death Facility Name (If not institution, give street and County of Death Examiner 1dells tow 9. Birthplace (State or Foreign Country)
OHIO If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday, 8. **Funeral** 1 ☑ M 2 □ F 220-20-3501 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1√2Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 W. BELVEDERE AVE. 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ∐Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK 2 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental P MASSIE MAE JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau ANITA DOWNING (DAUGHTER) 16 SUDBROOK LANE PIKESVILLE. MARYLAND 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Ofemation 3 X Removal from State 5 Other (Specify) 4 Donation ROLLING GREEN MEMORIAL 3-19-2010 WEST CHESTER, PENNA 21. Signature of Fano D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest by heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ause (Final **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 icate has been si ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe Yes of Vital 1 ☐ Yes ated 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No MOSPIZE 1 🗍 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 10 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and a less of promise who completed cause of leath

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32. Re

DHMH 17 Rev 1/2001

Item 23a) (Type, Print)

istrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Deat Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number 9. Birthplace (State or Foreign Country POLAND 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 □**X**F 1277071913 219-42-0502 96 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tyes 2 No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1840 REISTERSTOWN ROAD, #317 21208 USA 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🛣 No 3 ♥ Widowed 4 □ Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) REGISTERED NURSE NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LOUIS WOLLACH MINNIE Mor.

it. Page 1 and 2 should.

it of Health and Mr.

"27 is mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVE MILLER/SON 12206 FAULKNER DRIVE, OWINGS MILLS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH ECEMENOR TEAL 3/23/2010 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Dther (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 25. Was case referred to medical æ 26. Place of Death (Check only one, 1 ☐ Yes 2 No Other 잍 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? injury 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director;

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

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State Registrar . Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line a for Maryland Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:00 PM MARC Edward Owen Newcomb, Sr. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3ALTIM DRE AGNES HOSPITAL If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**⊠** M 2□ F 2/28/23 Director 87 Marvland 215-16-5394 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ¥ No Director MD Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 9906 Postwick Rd. 21042 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: þ 3 Nidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Engineering 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Percy Owen Newcomb Mary Elizabeth Snyder ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) /_Son 9906 Postwick Rd. Ellicott City, Maryland 21042 <u>Edward O. Newcomb, Jr.</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 3/25/10 4 Donation 5 Dother (Specify) Baltimore, maryland 23a. Part 1. Enter the disease, or co-polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or polar failure. List priv one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

22. Name and Address of Facility

Loudon Park

3620 Wilkens Ave. Baltimore.

WALLGNANT MCCAMIC. Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 Approximate Interval Between Onset and Death Physician /Medical Examiner YEARS HRONIC ASBESTOSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) $N \in \mathcal{WCOMG}$ $\mathcal{G} \neq \mathcal{DWARQ}$ Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed is certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an leaui: 1 XYes 2 🗆 No 1 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director:) 2 Accident 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 29c. License number D0037359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD21229 900CATON) AVE KRISM, SH. 31. Date filed (Month, Day, Year) SHE 32. Regist 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year . 10 P M Olivier 201 Dorothea Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Wash. Medical Center Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs, 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Funeral 215-18-9397 1 □ M 2 🎗 F 88 Months Days Hours Min. (Month, Day, Year) Director Sept. Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be martical annow. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md. Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 8352 Sail Circle 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 K No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify. White Specify. 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8 t.h College (1-4 or 5+) Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Harry Jeffries Marv Neisser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina M. Drgas (Daughter) 8352 Sail Circle Pasadena, Md. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cem. 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/25/10 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part 1. Enter the "sease, or complic tions that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🛱 No for Dav Year Pregnant at time of death 9 Unknowh Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No page 2 s has this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🕽 No Other: 1 Tes မှ 1 🖾 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury 1 🔀 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46536 3 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre BW M Oshrea 31. Date flied (Month, Day, Year) 32. Registrar's Signature State

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Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Lottie Phillips-Daley MARCH 2010 1443 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 39 LT IMORE er 1 Year | If Under 24 Hrs. AGNES HOSPITA Date of Birth (Month, Day, Sept 23, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 XXF Min. Months Days Hours 040-30-5552 79 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Anne Arundel Hanover 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1507 Beaver Dam Court 21076 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 □ Yes 2 🕅 No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jake Phillips Cordie (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1507 Beaver Dam Ct., Hanover, MD 21076 Gretel Foster-Boatwright 20b. Place of Disposition (Name of cemetery, crematory or other place Mountain View Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mar 29, 2010 Bloomfield, CT 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign w rul f Funeral Service Live 22. Name and Address of Facility Fink Funeral Home, P.A. Gregory Fink 23a. Part I. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List on one cause on each line.

Immediate Cause (Final disease or fondition resulting in eath)

a. The state of the death of the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List on one cause on each line.

The state of the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List on one cause on each line. M01148 426 Crain Hwy S., Glen Burnie, MD 21061 Approximate Interval Between Onset and Death DAYS Due to (or as a consequence of): PLEURAL EFFUSIONS MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HEMOTHORAX VZIN FROMBOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2**X** No 1 □ Yes 1 🔲 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2XNo ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending t □Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the death certificate be executed and attending physician P.0. ed by the detached Records, law requires Physician: The certificate of Vital this e Hospital or Attending Ph 24 hours after death. e Funeral Director: After th

24 hours a

To the within 2

Examine Physician/Medical Completed Be Certification: To

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

\$

Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Mental Injury or other traumatic event.

Physician

/Medical

Examiner

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)

Killyn Gatherna

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EVEL'IN GATHECHA 900 SCATON AVE BALTIMORE MD

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

P23490

29d. Date signed (Month, Day, Year)

22 2090

MARCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **FRANCES** March 23,20/10 12:30A **PATTERSON** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5711 The Alameda Baltimore None 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept 16, 1927 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M **2XX** F Country HIO Months Days Hours 290-22-5276 Yrs Director Usual Residence of Deceder filed within 72 hours after death with the Maryland ad other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore XX Yes 2 No None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 5711 The Alameda USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No lo lf Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXNo Specify: Completed 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Voucher Examiner U S Coast Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ပ Carroll Ensor Hauck Allie Marie Webster permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 P 0 Box 111116 Olympia, Washington 98508 Patrick Patterson Son Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Parkwood Cemetery Mar 25,2010 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) nature of Funeral 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Leath Immediate Cause (Final Physician disease or condition VOV1102 Medical resulting in death) Due to (or as a confequence of) Examiner Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after deau.

To the Funeral Director: After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 303 30. Name and address of person who completed cause of death (Item 23a) (Type NUR

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2010 Physician/ Month ELEANOR LEAH BOYER PHILLIPS March 22 5:10 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County GILCHRIST HOSPICE CENTER Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, You) 6. Sex Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Hours **Director** Yrs MARYLAND 220-05-9726 90 Usual Residence of Decedent or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore County 1 Yes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 6451 North Charles Street 21212 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. , or ò 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🄀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'lury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Murray Bover Hester Ann Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nancy P. Garrett (Daughter) 112 Beech View Court, Towson, Maryland 21286 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Green Mount Crematory 3/24/2010 Baltimore, Maryland 21. Signat of Juneal erviet seems

Nartin D. Laws MINCHELL WIEDEFELD FUNERAL HOME, INC. Lawson 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0513 disease or condition 115 Medical resulting in death) Due to (o) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 L Yes 2 D 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 WNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has performed? ☐ Yes 2 🚺 No death? 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ျု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dea h 1 Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 5 Pending work? 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar chango ST TENSON M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March Flora Virginia Paris 2010 5:35 P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital E1kton Cecil Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 2, 1 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours 1 □ M 2 🖾 F Min. Maryland **Director** 217-20-7692 85 Ĩ'925 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cecil E1kton 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2391 Old Field Point Road 21921 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after Yes 2x No Maryland 21215-0036 1 ☐ Yes 2 K No Specify: white If Yes, Give "natural", 3 ☑ Widowed 4 ☐ Divorced Year or Dates event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) bookkeeper grocery store Be permit. Page 1 and 2 should be filed to Department of Health and Mental Hyg Important; If item 27 is marked othnany injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ James Karsner Allen Eva May Evland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenna Clendaniel/daughter 21646 Karapathos L<u>ane; Spring, Texas 77388</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Dother (Specify) 21. Signatur of Funeral Service Licenses Wade ²² State Anatomy Board; 655 W. Baltimore Street Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Ectopic pregnancy Month Day Year signed by the a 1 ☐ Yes 2 ↓ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 2 10424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Maryla		artment of F		and Ment	al Hygien	71111	09038
		31	Decedent's Name (First, Middle	, Last)						ate of Death		3. Time of Death
	Physici: /Medic		DORIS	,	1201	LEN				onth Da		0 3.04 A M
	Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location o	of Death	40	. County of Dea	th
Ŷ/	2015 1 ± _			Virono			Baltimor				Balti	
	Funeral		5. Social Security Number 212~28~8434	6. Sex ' 1 □ M 2√□ F	7. Age (In y	rs. last birthday) Yrs.	Months Days	If Under 2 Hours	Min. (M	ate of Birth fonth, Day, Year). 3, 19) C	rthplace (State or Foreign ountry)
. 46a	Director		Usual Residence of Decedent		02				Feb). 3, 19	20 Ma	ryland
-	ylalle how at		10a. State 10b. County		10c.	City, Town or Lo	ocation					10d. Inside City Limits
2	la-f sl	ctor	Maryland Baltin	ore		Baltim	ore Count	у				1 □ Yes 2√XNo
14.	or 28	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What C	ountry?
4	s 23a		5634 North Lane	40 Was D		11.0	212		-i-0 (Ci/-)	/ N-	USA 14. Race - Am	orion Indian
- 7	item iner r	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marri	Armed	ecedent Ever ir Forces? es 2 17 No	10.5.	Was Decedent of H If Yes, specify Cub	an, Mexican	gin? (Specify Y i, Puerto Rican,	, etc.)	Black, Whi	
20	al", or	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Year o	es 2 No GiveXX r Dates:		1 ☐ Yes 2 🙀 No	Specify:			Specify: W	hite
	natur lical i	Completed	15. Decedent (Specify only highes		ed)	16a. Dece	dent's Usual Occup	ation	t of working	16b. I	Kind of Business	s/Industry
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7	her th	ပိ	11 yrs. 17. Father's Name (<i>First, Middle, I</i>	2 y:	rs.		Missiona		r'e Name /Firet	Spi t, Middle, Maide		Ministry
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<u> </u>	h and Mental Hygiene. 7 is marked other than " fraumatic event, the Mec	۲	19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street	L				<u> </u>
, Ma	Health ar Health ar em 27 is other trau		Nancy L. Wilson		er)		Lakeland					
ע -	of Her item		20a. Method of Disposition	• -		b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. L	ocation - City o	r Town, State
	rages nent of l ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		G State		of Faith		-26-201	.O Bal	timore,	Md.
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	7116 7/2		23a. Part1. Enter the disease, or	•	at caused the de						d. 2120	Approximate Interval Between
D	hysician		shock, or heart failure. List	only one cause o	on each line.	0				,		Interval Between Onset and Death
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YOU THE	attending ph	M/M	IF FEMALE: 23b. Was decedent pregnant		outcome pf pre						23d. Date of de	elivery
	d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pre	re birth 2□F egnant at time o		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			Month	Day Year
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ָה בַּבְּ	gned gned be de	by F	Part II. Other significant conditio		o death but not i اسماً	resulting in the u	inderlying cause giv	en in Part I.	. 2			to the cause of death?
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ט פ	nas b	Completed	Thron	nso cyto.	Panie	}			2	4a. Was an autopsy	prior to	utopsy findings available completion of cause of
	cate , pag	Con	Otreal	Fron	llatin				11	performed? ☐ Yes 2 ☐ N	death? 1 ☐ Ye	
V III	r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			et all DOA Oth	or.	of Death (Che			
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2 5	ector by th	ifica	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	200. Fic	ace of injury - A	t home, farm, str	reet, factory, office		28f. Lo	ocation (Street a ity or Town, Sta	nd Number or F	Rural Route Number,
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4	ithin (Medical	one) 29b. Signature and title of certifier	and m	nanner stated.		29c. Licens	e number		29d. D.	ate signed (Mon	ith, Day, Year)
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0	1		30. Name and address of person v	who completed of	ause of death (I	tem 23a) (Type.		, ,	1		, , , , ,	
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	Sta		31. Date filed (Month, Day, Year)		2. Registrar's Sig	gnature	backer			, , ,		

DHMH 17 Rev 1/2001

10-02219
Brenen Antonio Phillips

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	Certificate o	of Death	Reg. No.			
me (First, Middle,Last)	Antonio	Phillips	2. Date of Death Month Day March 19, 2010	Year	3. Time of Death 0345 hrs	

		Registrar		Jeruncai	e oi	Dealli			Reg. No).		
Physici edical Exami			Anton	io			llips	2. Date of De Month March 19	Day 9, 201			3. Time of Death 0345 hrs
		4a. Facility Name (if not institution, Southbound Route 301)	•		4	b. City, Town, or I Bowie	_ocation of Dea	th		c. County of Prince Ge		's
Funeral		Social Security Number 6	. Sex 7. Age (In y	rs. last birthd	lay)	If Under 1 Year	If Under 24H	_	Birth (MN			hplace (State or
Director		121-68-5243	1XM 2 F 2	5	Yrs.	Months Days	Hours Mi	n. 10	14	84	Foreigi Cou	intry) NY
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w any		10a. State 10b. County		City, Town or								10d. Inside City Limits 1 Yes 2 X No
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Mar or 28a	Director		•			10f. Zip Code	0705		10g. CI	itizen of Wha		try?
ith th		12011 Bork Dr	12. Was Decedent Ever i	niis Ia	3 W/20	Decedent of Hisp	0735	Specify Ves or N	do-	U.S.		can Indian, Black,
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 X Never Married 2 Marr	ied Armed Forces?			es, specify Cuban,				White,		arr maran, brass,
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ours a	q pe	15. Decedent's Education (Specification)	y only highest grade completed			's Usual Occupations of working life.			16b.	Kind of Busi	iness/Ir	ndustry
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	om	12th grade 17. Fether's Name (First, Middle, Li	na na	Con	str	ruction		r ne (First, Middle			uct	ion Co.
al Hylor	Be C	Larry Phillip	•					1 Quar				
212 Suld bould by Ment	To E	19a. Informant's Name/Relationship		19b. I	Mailing	Address (Street					, State,	Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I ament of Health and Mental Hygiene and "matural", or items 23a or 28a-fahe or other traumatic event, the Medical Examiner must be notified at once		Crystal Quarl	es-Mother			Bork 1						
s l an of Hea If iten		20a. Method of Disposition 1 X Burial 2 Cremation		Ob. Place of to crematory		tion (Name of cem er place)	etery,	Date	20c	Location - 0	City or 1	Town, State
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Baltimore, MD 2 pernit. Pages I and 2 shoul Department of Health and M Important: If titem 27 is m injury or other traumatic.		2T. Signafure of Funeral Service Li	ensee		22. Na Mar 430	ame and Address Ch F/H Wabas	of Facility West sn Ave	, Balt	imc	re, l	Mđ	21215
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/Medical Examiner		Immediate Cause (Final disease	a. Multiple Injuries									Death
		or condition resulting in death)	Due to (or as a consequence	ce of):								
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Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Unkno	9 Unknown	۰		er (opcomy)						
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Vital Records, P.O. bysician: The law requires that the this certificate has been signed by I director, page 2 should be detach.		-								✓ No 3		
ord aw req as bee	ompleted								psy	pri	or to co	opsy findings available ompletion of cause of
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f Vi Physical chils ral dir	은	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outp			at Work?	ing Home 5		ence 6		Scene
Division of Vital Records, P.O. Box 6 within 24 hours after death certain the Hospital or Attending Physician: The law requires that the death certain 124 hours after death. After this certificate has been signed by the attendition to the Funeral Director. After this certificate has been signed by the attendition by the funeral director, page 2 should be detached for use.	Certification:	1 Natural 5 Pending 2 Accident Investig	Mar 19, 2010 ear)	0335 h			es 2 V No	Driver in a				collision
ivisior 1 or Attend after death Director: d in by the	tific	3 Suicide 6 Could r				t, factory, office bu	ilding, etc.					al Route Number, City oad , Bowie , MD
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only Certifying Phys	sician: To the best of my know ner: On the basis of examination and manner stated.						e and pl	ace, and due	e to the	cause(s)
[, [3	ž	29b. Signature and title of certifier				29c. License						th, Day, Year)
		tamele Therhoe	(1, mD)			O.C.N	1.E.		Ма	rch 19, 20	J10	
1./		30. Name and address of person with Pamela E. Southall, MD			111	Penn Street,	Baltimore	MD 21201				
λ ^ν		31. Date filed (Month. Day, Year)	32. Redistrar's Sign		111	. Cilli Glicel,	Januario e,	110 2 1201				

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 7:50pm M Richardson Medical 3/16/2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges **Examiner** Moore's Nursing Home Mitchellville . Social Security Number 186–16–1549 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Billing (Month, Day, Y Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 1 □ M 2**XX** Months Hours Min. 88 Director Usual Residence of Decedent shov 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Prince Ge rges Upper Marlboro XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1603 Robert Lewis Avenue 20774 Funeral USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2XXNo Specify: Yes Give Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 6 Teacher School other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or out. Charlie Richardson pe Melissa Pickett Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Pickett Johnson/Cousin 124 Gooch Rd Eastman GA 31023 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Kemoval from State 3/20/2010 Rozier Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Eastman, Victor P. 21 Signature of Funeral Service Licensee Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ nddisease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Examine Due to (or as a consequence or): it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 J sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforr To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; f. Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural iniury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🕿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 1000 59182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FT Meade Rd #109 Lawelmo20724 MD erru

DHMH 17 Rev 7/2009

State Registrar Year)

trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	rylan		artment o			nd M	-	giene Reg. No.	0 0)	09041	
	Physici /Media		1. Decedent's Name (First, Middle, Last) Bray ford			Re	ynol	ds.			2. Date of De	人 Day 2		510	3. Time of Death	
	Examir	ner	4a. Facility Name (If not institution, give s The Johns Hopkins Ho 5. Social Security Number 6. Sex	spital	(In vrs. I	ast birthday)	Ab. City, Tow Baltimo	ore			8. Date of Birl		ounty of De		e (State or Foreign	_
	Funeral Director		218-66-1677 Usual Residence of Decedent	X M 2□F	54	Yrs.	Months D	ays	Hours	Min.	(Month, Da 12/20	y, Year)	1 . 2	Country)	MD	
	the Maryland 28a-f show lottfled at	Director	10a. State 10b. County MD Carrol 10e. Street and Number	1	10c. City	Westm:	inster	do				10g. Citizer	of What C		. Inside City Limits 1 ☐ Yes 2 🔀 No	
	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tien 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Di	207 Garden Way	12. Was Decedent E Armed Forces?		3. 13. V	21	115		in? (Spec	cify Yes or No-	U	SA Race - Am Black, Wh	nerican	Indian,	_
-0036	2 hours afte atural", or I cal Examin	by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu		0	16a. Deced	Yes 2X1	t No ccupa	Specify:			S	pecify: B	1acl	c .	_
21215-0036	filed within 7; Hygiene, other than "ni ent, the Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4 or 5-1	+)	life. L	kind of work do DO NOT use re ique De	etired)	er				f-Emp	loy•	ed	_
Maryland	should be fil and Mental H s marked oth umatic event	To Be	Bradford Richard 19a. Informant's Name/Relationship (Type		, Sr		a Address (St		Op	heli	(First, Middle) a Smit! I Route Number	h		Zin Co	nde)	-
re, Ma	es 1 and 2 sho of Health and I fitem 27 is me r other trauma		Iris Sheppard/Fr	iend	20b. P	952		ose of	Ct.,	Co1	umbia,	MD 2				
Baltimore,	permit, Pages Department of I Important; If its any Injury or o		1 Burial 2 XCremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License			Carro	ll Crem	nat	ory	_	/2010 al Hom		field remat			
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final	e cause on each line	+	. Do not ente					Rd.,		e1d,]	Ap	21784 oproximate terval Between nset and Death	
>	Physician /Medical Examiner	-	disease or condition resulting in death) Sequentially list conditions, if any leading to imm, distributed to the conditions of the condit	Due to (Ir as a	consequ (C)		opath	11/2	Ca	rdi	amyo	path	١٧			
1,097	ate be executed hysician and the bunal-transit	dical Examiner	if any leading to imm, districtures cause. Enter Underfung Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a	consequ						1					
P.O. Box 68	Ine law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	2 🗌 Fetal	death 3	Ectopic pregr Other (specify			٠		230	d. Date of d Month	elivery Da	y Year	
rds, P.	v requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but	t not resu	ulting in the u	nderlying caus	se give	en in Part I.		23e. Did to	1			cause of death? y 4 🗆 Unknown	
_	- 0	Completed									24a. Was a autop perfor 1 \(\supers \text{Yes} \)		prior to death?	o comp	findings available letion of cause of	
₹ :	Attending Physician: In it death. setor: After this certificate I by the funeral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:				Other			Check only or					_
	this alo	2	1 Yes 2 No	1 Inpatient 28a. Date of Injury		ER/Outpatient 28b. Time of	28c. I	Injury	at at		e 5 🗌 Resid 3d. Describe h			ecity)		_
<u>.</u>	th. : After e fune	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear)	Injury	'	Work?	es 2 □ N							
DIVISION	or the frostprai or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	y - At hor (Specify)	ne, farm, stre	et, factory, offi	ce		28	Bf. Location (S City or Town		Number or i	Rural R	oute Number,	
	24 hou 24 hou Funer letely fil	edical	29a. Certifier 1 Certifying Phys (check only one) 2 Medical Examin	ician: To the best of ner: On the basis of e and manner state	examinati											
	vithin To the compl	Me	29b. Signature and title of certifier	b 1.		•	29c. Lice				:	29d. Date s	igned (Mon	nth, Day	; Year)	_
			· Tell	M876				ES	,-00	0		mar	ch	12	,2010	_
			30. Name and address of person who co		ath (Item	23a) (Type, F	Print)		6	00 N	orth Wo	lfe St.	Baltim	ore.	, MD, 21287	7
Г	Sta Registra	re.	31. Date filed (Month, Day, Year)	32. Registrar's	s Signatu		1									

DHMH 17 Rev 1/2001

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Registrar

MAR 24 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 8:10 A M Physician/ M984 21, 2010 Mahawa Sylla Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days (Month 1 Day, 14969 Hours 1 □ M 2XX F Conakry Director 41 Yrs N/A
Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 XX No Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Africa 20906 12605 Lay Hill Rd # 202 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2XX No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Black 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) n/a College (1-4 or 5+) Own Business Hair Braiding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mafoudya Fadiga Sakoba Sylla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2415 Creston Ave # 53, Bronx, NY Cousin Mahamed Fadiga 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) XX Burial 2 Cremation 3 XX Remove from State Cimitiere Du Cameroon 4 Dometion 5 Other (Specify) Mar 29, 2010 Cameroon, Conakry 21. Signature of Euler Le Vice Hounse 22 Name and Address of Facility, P.A. M01148 K.\ ink Gregory 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caust (Final Severe Sepsis & Septic Shock Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Gram Negative Bacteremia Sequentially list conditions, Due to or as a consumence of cause. Enter Underlying Cause (Disease or iinjury Urinary Tract Infection Examir the Hospital or Attending Physician: The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed l irector, page 2 should be det 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XX Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2xx No 1 ☐ Yes 2 KZXN within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XXNo 1XX Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: XX Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check only one)

31. Date filed (Mog

29b. Signature and title of

3

QQ

29c. License number

D0067279

20910

29d. Date signed (Month, Day, Year)

Mar 21, 2010

Chester Russell Souza

Please Type or Print in Black Indeiible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 9044

		1- For State Registrar	,	Certific	ate of De	eath			R	eg. No.	ΙU	0 0 0 0 4
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Chester R							Date of Dea Month March 21,	th Day Yea	ır	3. Time of Death 1840 hrs
1		4a. Facility Name (if not institution, give 500 Upper Chesapeke Drive				ity, Town, o	or Location of	of Death		4c. County of Harford	of Death	
Funeral Director		5. Social Security Number 027–36–7715 6. Sex	7. Age (In your 2 F 65	rs. last birt		Under 1 Ye	_		8. Date of Bir	th(MM/DD/YYYY 15	Foreig	thplace (State or n untry) MA
nd show any ice.	١	Usual Residence of Decedent 10a. State 10b. County MA Plymout		City, Town	or Location Marshf	ield						10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 17 Liberty Road	d .		10f	. Zip Code 02	2050		1	og. Citizen of Wh	at Coun	ntry?
5-0036 libel within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-fahe the Medical Examiner must be notified at once	Funer	1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 122 Yes 2 No Yes, Give Year 1966-	0	If Yes, s	pecify Cuba	ispanic Orig in, Mexican, o specify:		ify Yes or No- can, etc.)	14. Race White	e, etc.	can Indian, Black, white
5-0036 led within 72 hours af tygiene. other than "natural"	Completed by	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	or Dates:) 16a. [Decedent's Us during most of	sual Occupa working life	ation (Give I	use retired		16b. Kind of Bus	siness/Ir	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Be Com	17. Father's Name (First, Middle, Last) Chester Souza				Me	18.Mother	s Name (F	irst, Middle, N	faiden Surname)		
nore, MD 2121 sges 1 and 2 should be fi nt of Health and Mental f: If item 27 is marked other traumatic event,	2	19a. Informant's Name/Relationship (Typ Jean Souza / W	Vife 	1	7 Libe	rty R	load,	Marsh	field	ber, City or Town MA 0205()	
F 2 2 2 2 1		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	cremato Couch	f Disposition (pry or other planet	ery		3/27	/2010	20c. Location - Marshi	fiel	d, MA
	y (d	21 Signature of Funeral Service License			23-33m1 1501	and Addres Es L. East	Stev Stev Fort	ens F Avenu	uneral e, Bal	Home, I	ínc D2	
Physician /Medical Examiner			therosclerotic Cardi le to (or as a consequence	ovascul			, such as ca	ardiac or re	espiratory arre	st, snock, or near	1	Approximate Interval Between Onset and Death
	iner	rause Enter Underlying Cause	e to (or as a consequence	e of):					<u> </u>	_		
executed an and al - transit	al Examiner		e to (or as a consequence	e of):								
760, icate be executed physician and the burial - transit	Medical		AMENDED 23c. If yes, outcome of pr	egnancy						23d. Date of d	letivery	
Box 687 ne death certific the attending produce as the	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at time of 9 Unknown	death 5	Fetal dea		Ectopic	pregnancy		Month	Da	ay Year
, P.O. E ires that the c signed by the	<u>ج</u>	Part II. Other significant conditions co	ontributing to death but no	t resulting	in the underly	ring cause (given in Par	t I.			_	ne cause of death?
cords law requ has been	Completed					•		_	24a. Was a autops perforr	y pri ned? de		opsy findings available mpletion of cause of
Tital Rec sician: The is certificate lirector, page	a	25. Was case referred to medical examiner?	pital: 1 Inpatient 2	FR/Out	natient 3		of Death (0			Residence 6	Other:	
ion of Vital rending Physician sath. or: After this certi	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year)		me of Injury	28c. Inju	ry at Work?	280		ow injury occurred	1	
Division To the Hospital or Attenditivithin 24 hours after death. To the Funeral Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At (Specify)	home, far	m, street, fact	ory, office b	uilding, etc.	28f	Location (St or Town, Sta		or Rura	al Route Number, City
D To the Hospital within 24 hours To the Funeral	Medical	one) 2 Medical Examiner: On ar	To the best of my knowle n the basis of examination ad manner stated.	edge, deat and/or inv	estigation, in	my opinion	, death occu	e, and due urred at the	to the cause time, date a	(s) and manner a	s stated	I. cause(s)
	Σ	29b. Signature and title of certifier	JA. w	ر یا	<u>. </u>	29c. Licens O.C.I		OCME	3	29d. Date signed March 22, 20		h, Day, Year)
1		30. Name and address of person who com Theodore M. King, Jr., MD.	Assistant Medical	Examir	ner 111	Penn Str	eet, Balt	imore, N	/ID 21201			
St Regist		31. Date filed (Month; Day, Year) —			house							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy Stank Month Sue 2:55P M March 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Hospice Center Timonium Baltimore Co. . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours April 23,1915 Months Min. 1 M 2 F Pennsylva<u>nia</u> Director <u> 20-14-0324</u> Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits irector 1 Yes 2 XNo MD Baltimore Dunda1k ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral hours after death with 52 Avalon Avenue 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Adam Baran Mary Spak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trat 21013 Gerald J. Stank (Son) 6102 Fork Woods Road Baldwin, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/22/2010 Baltimore, Maryland Stanislaus Cem Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21. Signature of Funeral Service Licensee Sie SHE 21222 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final disease or condition Onset and Death Physician, Alzheimer Stage ment Medical resulting in death) Due to (or as a consequend of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit Exami executed that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician stached for use as the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day signed by the a g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed as been si 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page ; performed Hospital or Attending Physician: The this certificate 1 Yes 2 No 2 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🗖 No 1 🗋 Yes ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After X Natural 5 Pending injury work death. 1 Yes 2 No М Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

SUE

18,

State Registrar only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dulaney Valley

DHMH 17 Rev 7/2009

imonium MO21093

29c. License number

29d. Date signed (Month, Day, Year)

Mariam Bakir CRUP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 20^{Day} 2010 Physician/ James Franklin Sandridge 12:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Edgemere 2410 Wythe Avenue 8. Date of Birth (Month, Day, Year) April 8, 9. Birthplace (State or Foreign Country) Virginia Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Min. 1**x** x M 2 Months Hours 218-28-4860 76 Director Usual Residence of Decedent ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.
It if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore Edgemere 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21219 2410 Wythe Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 X Married <u>چ</u> Maryland 21215-0036 1 Yes 2X No Specify: Completed 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Years Steelworker Steel Industry Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby M. Shifflett Roy F. Sandridge, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Sandridge (Wife) 2410 Wythe Ave. Edgemere, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 3/24/2010 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave Dundalk r complications that au, ed the death. Do not enter the mode of a ing, such as cardiac or respiratory arrest, art 1. Enter the disease or complications that shock, or heart failure List only one cause on e Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Saque, itiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Examin bi and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to a hours after death.
Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 22.060 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, I

RO201

Registrar's Signature

PRRT NED 2122

10-02138 Michael Leo Swift, III Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 09047

		l- For State Registrar		Certif	icate of	Death			Reg. No.			
Physicia		Decedent's Name (First, Middle,La	st)					2. Date of De	eath			3. Time of Death
Medical Examii	ner	Michael I	Jeo S₩	ift,	III			Month March 16	Day 5, 2010	Year)		1121 hrs
		4a. Facility Name (if not institution, gi 1238 Allview Drive			4	b. City, Town, or Hampstead		eath		. County of	Death	
Tunaval	-	5. Social Security Number 6. S	ev 7 Age	(In yrs. last	hirthday)	If Under 1 Year		1Hrs 8 Date of F			9 Rinth	place (State or
Funeral Director		220-78-8543	M 2 F	45	Yrs.	Months Days		Min. Aug.			Foreign	
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location	on						10d. Inside City Limits
* .	ě	MD		Balti								1 XYes 2 No
ne Maryland or 28a-f sho	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of Wha	t Count	ry?
h the 3a or		3654 Benson Ave				212	27		1	USA_		
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Memal Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she ir traumatic event, the Medical Examiner must be notified at once	/ Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorce	12. Was Decedent Armed Forces? 1 X Yes 2 d If Yes, Give Yea Pea	No	If Ye	Decedent of Hises, specify Cuban	, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		14. Race - White, Specify:	etc.	an Indian, Black,
ours a	황	15. Decedent's Education (Specify of			a. Decedent	's Usual Occupat	ion (Give kind			Kind of Busi		
72 hc	턀	Elementary/Secondary (0-12)	College (1-4 or 5	+)	during mo	est of working life.	DO NOT use	retired)				
1036 vithin 72 ene. er than "	Completed	12			Elect	ronic Te	ch.		S	tate l	Hwy	Admin.
5-00 iled wit Hygien Jother		17. Father's Name (First, Middle, Las	•					ame (First, Middle				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	B	Michael Leo 19a. Informant's Name/Relationship (Swift, J		40h Mailine	Address (S)	Mary			aker	0) 1	7. 0.1.
MD 2 Id 2 shoul thth and M n 27 is m nummatic	유	Mary A. Swift (,, ,	1.0		,		or Rural Route No		•		Zip Code)
ore, MD 2 s 1 and 2 shou of Health and N If item 27 is n	ŀ							altimore Date		Location - C		own, State
1 2 2 2 2 Z	- 1	20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from Sta	te Balti	more (erplace) remator	у @	/22/10	D -	1		M 1 1
Baltimo permit. Page Department of Important: injury or otl	-	4 Donation 5 Other Specification 5 Other Spe	<i>!:</i>	Carried Statement of the Control	Loudor	ı Park	J	/22/10 oudon Pa:	ba.	TEIMO	re,	Maryland
Balt permit Depart Impor	Į							ve., Bali				
Physician	7	23a. Part I Enter the disease, or com		the death. Do								Approximate Interval
/Medical	H	failure. List only one cause on e Immediate Cause (Final disease a	ach line. Contact Shotgur	. Wound	of Head							Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conse		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						-	
		Sequentially list conditions,										
	ij	if any, leading to immediate rause. Enter Underlying Cause	Due to (or as a conse	quence of):								
ed	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):								
ficate be executed g physician and stee burial - transit	Physician/Medical	UNPENDED	AMENDED									
760, ficate by g physic s the bun	ě	IF FEMALE:	23c. If yes, outcom			-			230	d. Date of d		
	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at t		2 Fet		Ectopic pre	egnancy	Į.	Month	Da	y Year
SOX death death e atter	ysic	1 Yes 2 No 9 Unknow	-	and or dodgr	5 Oth	er (Specify)			200			
O. B. at the de lby the tached i		Part II. Other significant conditions	contributing to death	but not resu	ting in the ur	nderlying cause g	iven in Part I.	23e. Did	tobacco	use contrib	ute to th	e cause of death?
P.C.	d b							_ 1 TY	es 2	/ No 3 □	Proba	bly 4 Unknown
ords, w requir	ete							24a. Wa	s an opsy			ppsy findings available mpletion of cause of
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Vita ysician ysician direct	o Be		Hospital: 1 Inpatier	nt 2 EF	/Outpatient		Other 🖂	ursing Home 5	Reside	ence 6 🗸	Other:	Scene
of ing Ph After t	-1	27. Manner of Death	28a. Date of Injur (Month, Day Ye Mar 16, 2010	y 28 ear) 1:	b. Time of In		ry at Work?	28d. Describe Subject sh			=	
sior trend death. cror:	lät lät	2 Accident S Pending	tion				∕es 2 ✔ No					
Division Hospital or Attendi 24 hours after death. Funeral Director: etely filled in by the f	Certification:	3 Suicide 6 Could no determine	De			t, factory, office b	uilding, etc.	28f. Location or Town, 1238 Allviev	State)			al Route Number, City
Hospit 4 hour funer		4 Homicide 29a. Certifier 1 Certifying Physic	cian: To the best of my			red at the time, da	ate and place.	7765	_		•	
To the Hos within 24 h To the Fun completely	Medical	one) 1 Certifying Physic 2 ✓ Medical Examine	er:On the basis of exam									
5.25.8	Me	29b. Signature and title of certifier	and manner stated.			29c. Licens	e number		29d.	Date signed	(Mont	h, Day, Year)
♥		my hi	· · ws			O.C.I	M.E.		Mar	rch 17, 2	010	
101.	}	30. Name and address of person who	completed cause of de	eath (Item 23	a)							
111		Ling Li, MD Assistant M	/ledical Examiner	111 Pe	enn Stree	t, Baltimore,	MD 21201					
St Regist		31. Date filed (Month, Day, Year)	32. Registrar 2.4 2010	Signature	A	parker	9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 29c, per DVR g901 3.24.10 TT
State of Maryland / Department of Health and Mental Hygiene
iteml per doc, 19a per inf g902 4-8-10 vt
Certificate of Death

Reg. No. 1- State amend iteml per 09048 1. Decedent's Name (First, Middle, Last) Keith Lewis Smith 2. Date of Death 3. Time of Death Physician/ Month Keith Smith 12:00 A M 2010 Mar 22 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Dayton Howard 4852 Ten Oaks Rd 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Min 1**№** M 2 | F Months Country Director Yrs 366-01-7810 Apr 9, 2022 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes a No Dayton MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21036 4852 Ten Oaks Road U.S.A Was Deceue.
Armed Forces?
Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Engineer / Sociology PhD Engineering / Sociology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Glenn Arthur Smith Marguerite Hoyt 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Guyton Smith Ruth Smith Spouse 4852 Ten Oaks Road Dayton, MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: It any injury or 4 Donation 5 Other (Specify) Mar 25, 2010 Marriottsville, Maryland Crest Lawn Memorial Gardens Si all re of Funeral Se elie 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that baused shock, or heart failure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreati Physician/ disease or condition resulting in death) month Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last is certificate has been signed by the attending physician director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death,

Director: After this certificate has because the second of autopsy ormed? No 1 🗆 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Hospital: 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1🕰 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo D61624 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 31. Date filed (Month, Day, Year) (MAR 24 gistrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March Jane Frances Shaffer 2 0°1 0 4:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sykesville Transitions Healthcare Carroll . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days 1 M 2 M 84 Director 210-12-1251 PA Usual Residence of Decedent or 28a-f show pernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 505 High Acre Dr. USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.' Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Je filed within.
Intal Hygiene. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) 5 + Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cloyde McCarty Ella Keith McCarty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clyde Shaffer-husband 505 High Acre Dr., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 3/25/10 Smallwood, MD Deer Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Homas 254 E. Main St.,Westminster,MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No Month Day signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No ၉ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred → Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 🚝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

two

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Milliam Calvin larch 2010 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner NIA Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director Usual Residence of Decedent 10a. Ştate 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notified at Baltimore 1 Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Wabash Avenue USA 21215 Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 Mes 2 □ No IMes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Hygiene. 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black \$ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Motors General h and Mental Hygien 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be Frank Sample Innie Gunter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Road Owings Hills, MD 21117 Marriottswille 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Antioch Church Cemetery Frankford, DE laughn C. Greene Funeral SVCS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Randallstown UD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Days /Medical Due to (or as a contequence of): Examiner vere malnutrition months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dysphagia Due to (or as a consequence of): months and P.O. Box 68760, signed by the attending physician be detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) JYes 2 □No a ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, Rena Failure 2 🔲 No 3 ☐ Probably 4 ☑ Unknown within 24 hours after deam.

To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 100 1 ☐ Yes **Division of Vital** To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ № Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Avenue Baltimore, MD 21227 hannarose

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 24 2010

LLIAM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2:53 AM Medical 2016 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical rs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 30-4229 Months 1 🗆 M 2 🖫 Hours Min. Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits Marylana 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3030 Bar 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Completed by 1 Newer Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 3 ₩idowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT (se retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relati nship (Type, Print) 19b. Mailing Address (Street and Nu City or Town, State, Zip Code) 5606 -daughter Inomas nel Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun Pervice Liceme 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Ap roximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Pregnant at time of death Month 2 No been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available After this certificate has page 2 autopsy performe prior to completion of cause of death?

1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No 은 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work? 24 hours after death. Funeral Director: A 2 🗌 No Accident Investigation 6 Could not be the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who compare ed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** Agnes Truett 20 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Center Baltimore Kosedale anklin Dquare If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Year) Min 1 ☐ M 2 🔀 F 104-24-0688 1,1926 North Carolina April Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is merked other than "naturel", or items 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Dundalk Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1956 Ewald Avenue permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 is merked other than "naturel" An interpretation of the traumetic events. 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Ş 3 X Widowed 4 ☐ Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dovie Roberts Virgil Hardin ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sallie Bolling (Daughter) Baltimore, Maryland 6 Pawleys Ct. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 3/25/2010 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the ust ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart silvine. List any one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin the disease or condition resulting in death) **Physician** -schemic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physician and for use as the burlal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 12 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Mann of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES 000 03/20/10

a) (Type, Print)

Franklin Square Drive Baltimore, Hangland 21237 Lin, MD Leu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIN ee 4000 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

09053

		•	For State Registrar	Olato o	i ivion	ylana	C	ertificate of L	Death		Re	eg. No.			
			Decedent's Name (First, Midd.	le, Last)							2. Date of Deat Month	h Day	Year	3. Time of Death	_
Н	Physicia /Medic				Arc	hie	R.	Thompson,	Sr.		March	20.	2010	3:10 A ^M	
The same	Examin		4a. Facility Name (If not institution	-				4b. City, Town, or				4c. Coun	nty of Death		
and the			713 Oakleigh						nda1k If Under		0 D-44 Bi-4b			ltimore Co	
	Funeral		5. Social Security Number	6. Sex MXM 2□ F	0	(In yrs. las	st birthda Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day,	Year)	Cour		,
6	Director		220-20-8217 Usual Residence of Decedent		8	3					Aug. 31	1926	Mary	yland	_
	/land		10a. State 10b. County	,		10c. City,	Town or	Location				_	1	0d. Inside City Limits	
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	h the	Director	10e. Street and Number	Darcinore				10f. Zip Code	<u> </u>		1	0g. Citizen o	of What Coun	ntry?	
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	ems	Funeral	11. Marital Status	12. Was Dece Armed Fo	rces?		. 10	 Was Decedent of Hi If Yes, specify Cuba 	ispanic Or n, Mexicar	igin? (Spec n, Puerto F	cify Yes or No- tican, etc.)		lace - Americ		
36	s afte	by Fu	1 Never Married 2 Mar	If Yes, Gi	2∏No ve)		1 □Yes 2 🔀 No	Specify:			Spec			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the MacTeal Everniner mast be rediffed at	d ba	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:		16a De	cedent's Usual Occupa	ation			16b. Kind of	Business/Inc	nite dustry	
 5	in 72 "na" n	Completed	(Specify only highe	est grade completed)	4		(Gi	ve kind of work done o . DO NOT use retired	turina mos	st of workin				·· ,	
212	with yiene	шо	Elementary/Secondary (0-12)	College (1	-40r 5+	'	G	eneral For	eman			Ste	el Inc	dustry	
פַ	al Hyg othe	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle, I	Maiden Surn	ame)		
<u>la</u>	should be fi and Mental H s marked ot aumatic ever	70	William Tho	mpson					Jan	iet l	lacDouga	a11			
ar	2 sho and l		19a. Informant's Name/Relations					iling Address (Street a							
Σ,	and 2 ealth n 27 i		Mrs. Kathryn	Thompson(Vife			Oakleigh						222	_
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the MacTeal Examinating mast be realised at once.		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation	3 Removal from	State	20b. Pla	netery, c	position (Name of rematory or other plac	- 1			20c. Locatio	n - City or To	own, State	
Ē	tmen tant: jury		4 □ Donation 5 □ Other (Specify)		0ak	Law	n Cemetery						Maryland	
Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licensee	0	,		22. Name and Address Duda-Kuck						ıc.	
	40 = 00		William Strange	C/Com		ho dooth	Do not	7922 Wise					222	Approximate	-
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en.	Physician /Medical		disease or condition resulting in death)	a	inal		mc	61						18mmms	-
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		Je.	Sequentially list conditions, if any, leading to immediate	b	(or as a	conseque	ence of):								_
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9			IF FEMALE:	-0.11											
Вох	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal	death	3 ☐ Ectopic pregnancy	у				Date of deliv Month	r e ry Day Year	
o	he de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unkr		time of de	alli	5 □ Other (specify) _							
σ.	res that the de signed by the a be detached f		Part II. Other significant condit	ions contributing to d	eath but	not result	ting in the	underlying cause give	en in Part	l.	23e. Did to	bacco use co	ontribute to t	the cause of death?	
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ta	sician: The certificate h rector, page	Be C	25. Was case referred to medica	al					26. Plac	e of Death	(Check only or		-12100		
>	di ib	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 □	Inpatier	nt 2 🗆 E	R/Outpa	tient 3 DOA Oth	er: 4□N	lursing Hor	ne 5 Resid	ence 6 🗆 (Other (Speci	ify)	
Division of Vital Records,	ding Pt h. After th funeral	uo:	27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date ng (Mor	of Injury	Year)	28b. Time Injur	y Worl			8d. Describe h	ow injury occ	curred		
sio	• Attendi er death. •ector: A by the fu	cati		tigation					Yes 2□	-					_
Ξ	or Atten after deatl Director: I in by the	Certification:		mined Zoe, Flack	of Injui	y - At hon (Specify)	ne, tarm,	street, factory, office		1	City or Tow		mber or Hur	al Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier	ing Physician: To the	e best o	f my know	/ledge_d	eath occurred at the ti	me, date a	and place	and due to the	cause(s) and	manner as	stated.	
	24 hd 24 hd Fun etely	edical	(Check only 2 Medica one)	Examiner: On the I	pasis of	examinati	ion and/o	r investigation, in my c	ppinion, de	eath occurr	ed at the time, o	date and plac	ce, and due t	to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifi	- 17	. / .	. 7.	1	29c. Licens	se number		:	29d. Date sig	gned (Month,	, Day, Year)	_
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	x1 /		30. Name and address of person	who completed cau	se of de	ath (Item	23a) (Typ	pe, Print) QIQ2	From	OVI	in 50.	Dr S	vite	2200	
9	7 V		uncu	476 ME1	EL	0	MA	1100		U IIU		Batt	mo	21237	_
	Sta Registr		31. Date filed (Month, Day, Year		gistra	r's Signati	re	hatel					,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:30 Ž010 Рм Tamberino, Sr. Anthony Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Marís Baltimore Timonium If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Months Hours 0171371927 MD **Director** 83 220-18-3834 ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County . Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 U.S.A. 4102 Taylor Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 1944-46
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: if item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me any ones. Elementary/Seconday (0-12) College (1-4 or 5+) Service Company Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tamberino Mary Dorazio Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4030 High Point Road, Ellicott City, MD 21042 Tony Tamberino, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 03/26/2010 | 4 Donation 5 Other (Specify) Gardens of Faith Baltimore, Maryland 22. Name and Address of Facility Signature of Funeral Service Licentee Leonard J. Ruck, 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform eral Director: After this certificate I filled in by the funeral director, pag 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29d, Date signed (Month, Day, Year) 2010 s of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM. MD 21093 JONES. CRNP

State Registrar filed (Morith, Day, Year)

ANTHONY TAMBERINO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

19a per FH G901 3/24/10 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 09055 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O.3 Thompson Dolores A . 2010 5:04a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 9224 Brewington Lane Laurel Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 C 7. Age (In vrs. last birthdav 8 Date of Birth Funeral Hours Of Month, Day Year) 1 - M 2 -XF Months Days Min Yrs 26 Director 83 578-34-4102 Usual Residence of Decedent or 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Laurel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20723 U.S.A. 9224 Brewington Lane 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. ⋧ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government 12th grade 4yrs+ Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ္ပ Cornelius Thompson Edna Scesco 19a. Informant's Name/Relationship (Type, Printriend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Janette Brown-Guardian 9224 Brewington Lane, Laurel, Md 20723 20b. Place of Disposition (Name of cemetery, crematory or other place)

National Harmony
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Landover, /10 22. Name and Address of Facility
March F/H West Signature of Funeral Service Licens Wahash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Hypertensia disease or condition Medical resulting in death) **Examiner** 200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown ☐ Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? certificate : After this certifical e funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)
March, 23 2010 29b. Signature and title of certifier 29c. License number 34974 Comenta Mo CHARUMENTA, MD 8775, Cloudley Ct 1224 (olmbra, MD21045-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

barker

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26, per ME 8901 3/24/10 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 21 Day 2010 3:47 P M Physician/ TEUTSCH, JR. THOMAS M Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL CENTER 9. Birthplace (State or Foreign If Under 1 Year | if Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 🔼 M 2 🗆 F **Funeral** 1/26/1947 Days Hours Min. Country) DC 577-68-2172 63 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 🗆 Yes 2 No GREENBELT PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20770 18 RIDGE ROAD, #N Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Black, White, etc. Armed Forces Yes 2 X No 1 Never Married 2 X Married þ ☐ Yes 2 X No Specify Specify. If Yes, Give Year or Dates WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) STATE OF MARYLAND REGISTERED SANITARIAN 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) BRENNAN မ MONICA **TEUTSCH** THOMAS M 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18 RIDGE ROAD, #N, GREENBELT, MD ROSALIE TEUTSCH/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 3/23/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of uneral Service Licen 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the a ld be detached f a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? 1 Yes this certificate 26. Place of Death (Check only one) within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 X Inpatient / 2 28d. Describe how injury occurred Shot himself 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at through mouth 5 Pending ☐ Natural ☐ Accident 1 Yes 2. No 1300 M MArch 17,2010 Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) ISN RISE Read Every Number of Number of Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined hom within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as dated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature and title of certifie

30. Name and address of person who g

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2010 arleen /Medical Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Date of Birth (Month, Day, Year) If Under 24 Hrs 1 Year Birthplace (State or Foreign Country) Social Security Number . Age (In **Funeral** Days Min Months 1 □ M 2 X F 220.30.6323 .26. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, "tw. "A. dical Exarcing Insist be rollined at 1 Yes 2 □ No MD Director att: more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Vas Decedent Ever in U.S. Race - American Indian, 11. Marital Status Black. White, etc. Armed Forces 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be မ City or Town, State, Zip Code) and Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, Health or other tra Saltimore, 20b. Place of Disposition (Name cematery, crematory or other Date 20c. Location - City or Town, State 20a. Method of Disposition ō 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Injury or Riesterstown Department of the portant: If any Injury of the porce. 21. Signature of Juneral Service Licer 21216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL Due to (or as a consequence of): INFARCTION hour disease or condition resulting in death) /Medical Êxaminer CORDNARY ARTERY DISERSE

Due to (or as a consequence of): 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine for use as the burial-tran and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical attending IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a the 1 ☐Yes 2 ☐ No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MORBID OBESITY certificate has page 2 MELLITUS 1 TYes 2 No DIABETES of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ø DOA 1 ☐ Yes 2 XNo 1 ☐ Inpatient _2 ☐ ER/Outpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? To the Hospital or Attending Division Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after uean...

To the Funeral Director: f investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 2264F MARCH 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerone Snyder
31. Date filed (Month, Day, Year) 900 CATON AVENUE BALTIMORE, MARYLAND State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1^{Day} March 2019 **Physician** 2:00 A M Benjamin Earl Wilson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 3505 Putty Hill Avenue Parkville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct 27, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 1 1 M 2 □ F 1919 90 Director 212-16-5073 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show MD Baltimore Parkville 1 ☐ Yes 21 No if item 27 is marked other than "natural", or items 23a or 28a-f si or other traumatic event, the Medical Examirer must be notified. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 3505 Putty Hill Avenue Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1★JYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2K Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if flem 27 is marked other than any injury or other fraumetic. Elementary/Secondary (0-12) College (1-4or 5+) education government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgianna Cordelia Willinghan Benjamin Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3505 Putty Hill Avenue; Parkville, MD 21234 19a. Informant's Name/Relationship (Type. Print) Dorothy Wilson/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☑ Donation 8 Other (Specify) Signature of Euneral Service Licensee Ronald S. Wa 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 3a. Par 1. Enter the disease, or complications that caused a shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease of indition resulting in death) **Physician** RI /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy for 1 Month Year 5 Other (specify) detached 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 3 No 1 ☐ Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) MAR 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony Serafis

1205 York Rd.# 32c Lutherville, Md. 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death March 21 Day 2010 Year Physician/ 12:52 PM ALEXANDER CHARLES ROBINSON WILSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 508 Overcrest Road Baltimore County l'owson 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min 1 🕅 M 2 🗆 F Months Day, Maryland Director 220-12-7992 83 Yrs Usual Residence of Decedent 23a or 28a-f shov 10h. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21286 USA 508 Overcrest Road or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1

Yes 2 □ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married WWII Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) Director of Engineering Tool Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fishers is marked o ၉ Mary Eleanor Martin Leslie Stewart Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is 14549 Manor Road, Phoenix, Maryland 21131 Alexander F. Wilson, Ph.D.(Son) Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/26/2010 Baltimore, Mount Crematory Signature Fune Al Service Vice Martin D. La 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, IN
6500 Vork Road, Baltimore, Maryland Jawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ma Physician/ disease or condition resulting in death) 119nant Cars Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir and I-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician arts the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending physi IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yeş s been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate ha performed? Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's 1 Yes 2 1 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner Death 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pendina within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D16534 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) Sister Pierre Drive, #105, Towson, Maryland 21204 D. Sokolow 120 Marc

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:04AM 2010 Javon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BOLLIMUV E If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | CSPITA 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year -38 -2212 1 M 2 □ F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Ext. wings must be inclined at 1 Yes 2 No Baltimore Directo NIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? morley St. 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 ☐ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black δ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Repairman Shoe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tda Cahi Williams Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HIberta Williams Baltimore, mo Morley St. -Wife 20a. Method of Disposition Date 20c. Location - City or Town, State 1. Burial 2 ☐ Cremation 3 ☐ Removal from State ownsville Crownsville, MD 26-10 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Lice. Address of Facility
Figure 7
Fredhilton Pass Fugeral Home P.A. h Pass Balto. MD 23a. Paul ner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final Arteriusclerate Vasevlar Di **Physician** disease or condition resulting in death) Hyperten sive Divide (or as a consequence of): Unknown /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physician and the dor use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown Cancer 2 No 3 Probably Completed nertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 🗷 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 □ Could not be 3 ☐ Suicide within 24 hours after de To the Funeral Directo completely filled in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical Medi and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Anes M \$2. Registrar's Signature 900 Coton Avenue Baltimore Morylant serge son 31. Date filed (Month, Day, State

Registrar

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b State of Waryland Department of Health and Mental Hygiene 2 1 1 for State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 1535 Medical Examiner 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or items 22 - - - any injury or other traumatic event. the Maryland once. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No more 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify. 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Be er's Name (First, Middle, Last) ည od of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ocardial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner tension Sequentially list conditions, if any leading to immediate Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events to acute on chronic renal failure sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2 c performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1. Natural 5 Pending iniun work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗂 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29c. License number 00066212 march 18,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway, Baltimore, Maryland 21218 McClosky mo 201 East University 31. Date filed (Month, Day, Year) MAR 24 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:10A M 18-2010 la /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1341 fimore
If Under 1 Year | If Under 24 19/607 Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 1 □ M 2 □ F Months Hours 216-16-5909 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modeal Examiner. Sust by notified as once. 1 Ves 2 No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life: DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) Be Da/ lewman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Granoldau Par 1200. Place 12/607 Place of Disposition (Name of gemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Y Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 11stown, mi) 21/33 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) burial-1 physician a Physician/Medical been signed by the attending should be detached for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed?

1 □ Yes 2 □ No page After this certificate funeral director, page Vital 1 Yes To the Hospital or Attending Physician: 25. Was case referred to prédical examiner? Be 26. Place of Death (Check only ope Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 →No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) o 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier FERNANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 122 DIGITM LIN THICUM MID Registrar's Signa State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09063 Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4b. City Examiner 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months **Director** 28a-f shov 10d. Inside City Limits 10a. State traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 ☐ No 10e. Street and Numbe 9 10g. Citizen of What Country? Funeral 23a items ; 72 hours after death Was Deceue... Armed Forces? Yes 2 No Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or Completed by 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DQ NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mec DO NOT use retired) College (1-4 or 5+) rse Be Maryland 17. Father's Name (First Middle, Last) ther's Name (First, Middle, Maiden e/ce Baltimore, od of Disp sition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Barial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Signature of Funeral Service Lic inseed 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Chementia Physician Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 24 No Pregnant at time of death Month Dav Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ia BETES mullitus Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🖵 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 2 🗆 No Investigation 2 Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anni) 35102 MAYCH 23, 2010

State Registrar Hilary

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

north

Street

Baltimore Marylano

CHAVLES

Name and address of person who completed cause of death (Item 23a) (Type, Print)

5901

32. Registrar's Signature

DON M.D

MAR 24 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #12, per FH g901 3/24/10 TT
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 0819 march 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death oves Baltimore n/a If Under 1 Year If Under 24 Hrs. Social Security Number ge (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours (Month, Day, Year) Maryland Director 216-20-3297 83 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a State 10h County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1107 Bayard Street 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 10 WWII 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify: 3 Divorced Specify. Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Yanke Anna A. Domicke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Yanke / Wife Mrs. 1107 Bayard Street Baltimore, Maryland 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/24/10 Brooklyn Park, MD. Hill Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 36<u>20 Wilkens Ave.</u> Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Can disease or condition) Medical resulting in death) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 2 No g Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1ddism 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 laccmen 2 🗌 No 1 Yes 25. Was case referred to me examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and transver as stated 29b. Signature and title of certifier au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 west etm ore MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and State Registrar State of Maryland / Department of Health and Certificate of Death		giene Reg. No. 2010	09065
Physicia	n	1. Decedent's Name (First, Middle, Last)	Date of Dea Month	ath Day Year	
/Medic		Mary Patricia Zambreny	March	23 2010	
Examine	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dear	th	4c. County of Dea	
_		244 Old Line Avenue Laurel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	S 9 Date of Birt	Anne Aru	indel rthplace (State or Foreign
Funeral Director		578-48-5547 1□ M 2⊠ F 72 Yrs. Months Days Hours Min	. (Month, Da		ountry)
	-	Usual Residence of Decedent	Aug 22	, 1937 Was	shington, DC
ylanc		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
a-fs	턍	MD Anne Arundel Laurel			1 □Yes 2 ☑ No
or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
72 hours after death with the Maryland 72 hours after death with the Maryland natural", or items 23a or 28a-f show	<u>a</u>	244 Old Line Avenue 20724		USA	
r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	- 14. Race - Am Black, Whi	
s affe	by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	,	Specify: W	·
2-UCSO 72 hours aft natural", or		3 ☐ Widowed 4 ☐ Divorced Year or Dates:			
n 72 n 1 n 1 n 1 n 1 n 1 n 1 n 1 n 1 n 1 n	ete	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of wo life. DO NOT use retired)	orking	16b. Kind of Business	,
r thar	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Administrator		-	ored Horse
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yland buld be file Mental H arked oth attlc even	To Be	John W. Shoap Mary E.	. Brashea	ars	
shour shour or mark	٠	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or R	Rural Route Numbe	er, City or Town, State,	Zip Code)
ire, ividi		Robert W. Zambreny, Sr./spouse 244 Old Line Avenue,	Laurel.	MD 20724	
Dallillore, Interview A 12 13 10 50 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and other traumatic event, the Medical Examination and once.		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City o	r Town, State
Page Page nent (TEADURAL 2 COMMISSION SERVICE STATES	30/2010	Burtonsvil	le MD
Dallimor bermit. Pages Department of mportant: If It any injury or o	1	Of Name and Address of Facility		Funeral H	
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		23a. Part Inter the disease, or compligations that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory as	rrest,	Approximate Interval Between
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1 /Medical		resulting in death) a. Due to (or as a consequence of):			1
Examiner	.	Sequentially list conditions b.			
pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter dridarying Cause (Disease or injury that initiated events c.			
and Ftran	Xau	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
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eath atte	Physician/M	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
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w requires that the designed by the should be detached	D P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
law requires that see a speed signer 2 should be considered.		MULTIPLE MYELOMA	1 🗆 \	∕es 2 <mark>)⊠</mark> No 3∏ F	Probably 4 🔲 Unknown
law re as bee	plet		24a. Was		utopsy findings available
The I	Completed			rmed? death?	completion of cause of s 2 □ No
Attending Physician: The lav artending Physician: The lav ar death. ector: After this certificate has by the funeral director, page 2 s.		25. Was case referred to medical 26. Place of De	ath (Check only o		3 2 1110
Physic this ce al direc	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing I	Home 5 KResid	dence 6 ☐ Other (Sp	ecify)
ding Phy I. After this funeral of		27. Manner of Death 1 Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Injury 28b. Time of 28c. Injury at 28c. I	28d. Describe h	now injury occurred	
SICIT tending leath. tor: Afte the fune	gatic	2 Accident investigation M 1 Yes 2 No			
or Att frer d irect	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined building, etc. (Specify)	28f. Location (8 City or Tov	Street and Number or F vn, State)	Rural Route Number,
pital of urs all number of the stal of the					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date occurred at the tim	ce, and due to the curred at the time,	cause(s) and manner added	as stated. ue to the cause(s)
To th To th comp	Ž	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	
		D21071		3-24-2	010
7 .	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
\ \		R. ANANDA KRISHNAN 821 N. EUTAN ST #305 B	94/1MOR	EMD	2/201
		31. Date filed (Month, Day, Year) 32. Redistrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 **Physician** 2010 6:25 AM Catharine Birley Arnold /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Brunswick 3 East E Street If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland Date of Birth (Month, Day, Year) 5/31/1912 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 💢 F 97 214-54-0346 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ntal Hygiene. do other than "natural", or items 23a or 28a-f shov event, the tradical Examinar mat be natified at 1 ☐ Yes 2**X** No Director Frederick MD Knoxville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3501 Petersville Rd 21758 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker d 2 should be filed w th and Mental Hygies 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nova Belle Hedges Ulysis E Smith or other traumatic ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a
Department of Health a
Important: If item 27 Is
any injury or other trau Knoxville MD. 21758 Shirley Cooper, Daughter 609 Tritapoe Dr. 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/12/2010 Brunswick Park Heights Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barbar 21716 John T Williams Funeral Home, Brunswick MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ana estive eass /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy detached for Month Day Year 5 ☐ Other (specify) ☐Yes 2 ☐No Ö signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform certificate 1 ☐ Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifict completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughters Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Spe \(\text{Residence} \) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier TXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2016 NWO 0258610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 010 Brunew.Ele entre 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State of Ma	aryland / Depa <i>Cert</i>	irtment of Hea tificate of Dea		ental Hygie _{Reg.}	_ / (111)	09067
	Physicia		1. Decedent's Name (First, Middle, Last)		•		2. Date of Death	Day Year	3. Time of Death
	Medic	al -	Pauline Travis Libes G	riffiths B	4b. City. Town, or Loc	cation of Death	March 5	4c. County of Death	0500 М
	Examin		Calvert Manor Healthcare C		Rising	Sun		Cec	
	Funeral Director		242-05-4603 1□M2♀F	(In yrs. last birthday) 89 Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth May 31, Pay, Ye	9. Birth Nort	nplace (State or Foreign h)Carolina
	ind ihow at	- H	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	eation				10d. Inside City Limits
	Maryla 28a-f s otified	irect	Maryland Cecil		Perryvil	le			1 X Yes 2 □ No
	with the s 23a or ust be n	Funeral Director	10e. Street and Number 507 East Cedar Point Drive	e	10f. Zip Code	903	10g	, Citizen of What Cou	untry?
<u>36</u>	e fled within 72 hours after death with the Maryland the Hygiene. At Hygiene. At other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ ☐ If Yes, Give If Yes, Give	No If	Vas Decedent of Hispa Yes, specify Cuban, M ☐ Yes 2 X No S	/lexican, Puerto F	oify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
Maryland 21215-0036	hours a natural lical Ex	Completed	Widowed 4 Divorced Year or Dates. 15. Decedent's Education (15.0)	16a. Deced	lent's Usual Occupatio	n na most of workin		b. Kind of Business I	ndustry
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Z	d 2 sho alth and 1 27 is r er traun		19a. Informant's Name/Relationship (Type, Print) Mary G. Park-Neureither (da						
Baltimore,	Page 1 and 2 should be file ment of Health and Mental I ant; If item 27 is marked o ury or other traumatic eve		20a. Method of Disposition 1	20b. Place of Dispos cemetery crem Salem Con	sition (Name of natory or other place) gregation evard	i	vate 15/10 Wi	nston-City or nston-Sal lorth Caro	Town, State em, lina
Baltii	permit. Page 1 Department of I Important: If it any injury or o	j	21. Signulure of Funeral Service License		Name and Address of ee A. Patt Perry	Facility Terson & VIIIe, I	Son Fune Maryland	ral Home 21903-076	6 ^{P.A.}
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~-!	ician/ Medical	f f	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a	a nsequence of):	Dement	ic			years
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3760	ficate b g physi as the b	Medical	d						
Box 68760	res that the death certific signed by the attending d be detached for use as	Physician/M	in the past 12 months? 4 Pregnant a	2 Fetal death 3 _	Ectopic pregnancy Other (specify)		-	23d. Date of del Month	ivery Day Year
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corc	law require has been si e 2 should l	Completed					24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
E Re	sician: The law r s certificate has b lirector, page 2 s	a)	25. Was case referred to medical		26. Place	e of Death (Check	1 🗆 Yes 2	No 1 L Yes	3 2 □ No
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Division of Vital Records,	or Atter after des Director	Certificate:		jury - At home, farm, str. c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check conly one) 3 Certifying Physician: To the best of Check conly one) 3 Certifying Nurse Practioner: To the	evamination and/or inves	stigation, in my opinion.	death occurred at	t the time, date and	place, and due to the	cause(s) and manner stated.
	To the vithin To the complete	2	29b. Signature and title of certifier		29c. License n	umber		d. Date signed (Mont	
)		30, Name and address of person who completed cause of o	death (Item 23a) (Type I	Print)			03/09/10	2
			Neile Lattin, M.D. 101	death (Item 23a) (Type, F	Day, Ris	ing Su	in, MD	21911	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Regist	ar's Signature	have				

10-02145 Michael Victor Bu		Sil- For State	pe or Print i tate of Maryl	and / Depa		f Health			giene	egible.	20	0 0906
Physicia	ո/	Registrar 1. Decedent's Name (First, Midd						2	2. Date of Dea		Year	3. Time of Death
Medical Examin		M. 4a, Facility Name (if not institution	ichael Vio			4b. City, Tow	n, or Locat	tion of Death	March 16	, 2010	County of De	2131 hrs
		Bowie Health Center	, 3	,		Bowie	,				ince Geo	
Funeral Director		5. Social Security Number 216-98-7391	6. Sex	7. Age (In yrs. la 45	st birthday) Yrs			Under 24Hrs. fours Min.		irth(MM/D 5/196	Fo	Birthplace (State or preign Country)MaryLand
and show any nce.		Usual Residence of Decedent 10a. State 10b. County Maryland Prince			Town or Locat	ion	Bel	tsville)			10d. Inside City Limits 1 Yes 2 X No
the Maryl	Director	10e. Street and Number 3113 Calv	erton Blv	d.		10f. Zip Co		705		10g. Citize	en of What C	country?
	Fune	3 Widowed 4 Div	Armed F 1 Yes Vorced If Yes, Give Ye or Dates:	2 X No			uban, Mex	: Origin? (Sperican, Puerto R		s	White, etc	White
36 in 72 hours han "natur iical Exam	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)		ade completed) 1-4 or 5+)	during m	ost of working	g life. DO I	Give kind of wo NOT use retire		16b. Kir	nd of Busine	,
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2121 uld be fi Mental J marked	e B B	Wesley 19a. Informant's Name/Relations	y Myron Buship (Type, Print)	itler	19b. Mailing	g Address (§	Street and	- (ral Route Nu			tate, Zip Code)
b, MD and 2 sho lealth and tem 27 is traumati		Wesley M. Butle 20a. Method of Disposition	er - Fath		3113 Place of Dispos	Calver	ton 1	Blud.,	Belts Date	ville 20c. Lo	. Mar	uland 20705 or Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tra	-	1 Burial 2 X Cremation 4 Donation 5 Other S 21. Signature of Funeral Services	pecify:	TOTTI State	rematory or ot	herplace) Ln Cre	.mato	ry 03/2	3/2010	Bre	ntwood	d, Maryland al Home, Inc
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Physician Medical Examiner	3	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line. e a. <u>Sei</u>	zure disc	order		ying, odon	ao saratas si i	oopii atory ar	7001, 01100	n, or mount	Between Onset and Death
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		IF FEMALE: 3b. Was decedent pregnant in to past 12 months? 1 Yes 2 No 9 Un	23c. If yes, 1 Live	outcome of pregn birth nant at time of dea	2 Fe	tal death		topic pregnand	çy		Date of deli	very Day Year
다른 호텔 ·	≥∣	Part II. Other significant condi	tions contributing	to death but not re	sulting in the u	underlying cau	use given i	n Part I.	_	_	se contribute	e to the cause of death? Probably 4 Unknown
of Vital Records, P.O. Box ing Physician: The law requires that the death After this certificate has been signed by the attenderal director, page 2 should be detached for undertail director, page 3 should be detached for undertail director, page 3 should be detached for undertail director dire	Completed		. –						24a. Was auto perfo	psy ormed?		
	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient		Place of De	eath (Check on	ly one) Home 5	Residence	ce 6 0	ther:
		27. Manner of Death 1 Natural 5 Pen	28a. Date (Mont ding estigation	of Injury h, Day.Year)	28b. Time of I	njury 28c.	Injury at V		8d, Describe	how injury	occurred	
Division Div	Certification:	3 Suicide 6 Cou		ce of Injury - At ho	me, farm, stree	et, factory, off	ice buildin	g, etc. 2	8f. Location (or Town, 9		d Number or	Rural Route Number, City
Division Division To the Hospital or Attent within 24 hours after death within for the Functed Director: completely filled in by the		(or real or real	Physician: To the be aminer: On the basis and manner	of examination an								
H 2 H 2	ž	29b. Signature and title of certification		1	/	1	.C.M.E.	nber			ate signed (h 17, 201	Month, Day, Year) 0
		 Name and address of persor Zabiullah Ali, M.D. 	n who completed cau Assistant Medic			n Street, E	Baltimor	e, MD 2120	01			-

State 31. Date filed (Month, Day, Year) NAR 19 2010 Registrar

Zabiullah Ali, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O3 Year GORDON HARLES 7:52A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Salis burn Wicomico 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or to. 10d. Inside City Limits Director 1 Yes 2 No $\mathcal{M}\mathcal{D}$ LICOMICO WALVE 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21814 CEDATHII A SU 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 Ar Specify Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PLANT MANAGER MOULTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental h Brun Lzy SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State sprenghal memory barbus 3-11-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

(Marin Jasuel B. Marin) 22. Name and Address of Facility MESSICK REMETAL HOME TO BOX 61 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ CHRONIC OBSTRUCTIVA disease or condition resulting in death) * DISIZASIZ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to minimizate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? □ No 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) HOSPICIZ ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After th completed filled in by the funeral. filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10e Per FH G901 3/25/2010 IH
State of Maryland / Department of Item 25 per Phys. G901 3/25/2010 Martal Hygiene
Amend Item 25 per Phys. G901 3/25/2010 Martal Hygiene
Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 4. Ρ. Burcham Robert [□]2010 5:55 A M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Harmony Hall Assistant Living Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Yea **Director** 577 24 7849 87 8 1922 North Carolina Ime Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Me in a Kaniner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral apt 326 6336 Cedar Lane #350 21044 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 NewWII If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√√ No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Director of Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ John B. Burcham, Sr. Margaret Poplin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7614 Stratfield Lane, Laurel, MD 20707 Russell G. Sharpe (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem 3-22-2010 | Cheltenham, Maryland 21. Si pat le d' Funeral Lerve Licens 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old aus Alexandria Ferry Road, Clinton, MD Trans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Zheimers Onset and Death 2 mentig Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to or as a consequence of After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 Hospital or Attending Physician: The 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other (Specify)} \) 2X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury in 24 hours after death.
the Funeral Director: Aft 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basic of examination and/or inventioning in a stated. Medical 29a, Certifier 2 Hedical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Murse Pylactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia Mary Isne (92513 (edur 334 31. Date filed (Month, Day, Year) State MAR U & 2010 Registrar

Please Type or Print in Black Indelible Ink 5 Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ebrurer 28 2010 <u>awrence McKinley Burgess, Jr.</u> /Medical 4a. Facility Name (If not institution, give street and number) cation of Death **Examiner** MEDICAL ENTER Birthplace (State or Foreign Country) If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 119-40-3569 11, 1949 New York 60 November Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f show Medical Exercises must be notified at 1X Yes 2 No Director Maryland Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 2716 Hale Court 20603 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Affiled Folices: 1 XYes 2 No If Yes, Give Year or Dates:1971-1975 1 Never Married 2 Married r than "natural", or i Maryland 21215-0036 1 □Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiern Important: If Item 27 is marked other tha any lighry or other traumatic event, the gonce. Park Ranger Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence M. Burgess, Sr. Myrtle H. Mabry ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2716 Hale Ct., Waldorf, Maryland 20603 Linda Burgess/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory March 8, 2010 Glen Bernie, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Huntt Funeral Home 3035 01d Washington Rd. Waldorf, MD. MOUGO 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition cardiac /Medical Due to (or as a consequence of): Examiner M05 Inc Sequentially list conditions, if any least a simple design cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical signed by the attending p IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🔲 Ectopic pregnancy Month Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DOO 92-52 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Name and address of person who completed cause of death (Item 23a) (Type, Print) Box 1070 La Plata MD 20646 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 8 2010 Registrar DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Cer	tificate c	of Death			Reg. No.	201	
Physici		Decedent's Name (Fire	st, Middle,Last)						2. Date of D		Year	3. Time of Death
ledical Exam	iner	Kim Louise	Floyd	Culler					March 7	7, 2010		2107 hrs
1		4a. Facility Name (if not in Shady Grove Ac		,			4b. City, Town, o	or Location of	of Death		County of E lontgome	
Funeral		5. Social Security Number			e (In vrs. la	st birthday)	If Under 1 Ye	ear I If Unde	er 24Hrs. 8. Date of		•	Birthplace (State or
Director		Unk- 219-76-	-66681⊡м			51 _{Yı}	Months Da		Min.	21, 1	F	oreign Country) Maryland
any		Usual Residence of Dece 10a. State 10b.	County		10c. City,	Town or Loca	ation					10d. Inside City Limits
ž "	_	MD Mo	ontgomer	v	Rock	ville						1 X Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number				<u> </u>	10f. Zip Code			10g. Citiz	en of What	Country?
th the Maryland 23a or 28a-f sho notified at once.		803 Wade	Avenue				20851			Unit	ed St	ates
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiers, and its firem 27 is marked other than "natural", or items 23a or 28a-f 5he uri. If item 27 is marked other than "natural", or items 23a or 28a-f 5he or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2	1:	2. Was Decedent Armed Forces?					in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - A White, e	American Indian, Black, etc.
her de		3 Widowed 4	Divorced If Y	es, Give Year	X No	1	Yes 21K N	o specify:			Specify Ca	ucasian
ours af Itural	d by	15. Decedent's Education	or	Dates:	pleted)	16a. Decede	nt's Usual Occup	ation (Give I	kind of work done			ess/Industry
5 72 ho m "ma	lete	Elementary/Secondary	(0-12)	College (1-4 or 5	i+)	during r	nost of working lif	e. DO NOT	use retired)			
othin ene.	Completed				1	Acco	ıntant			Ame	erican	Chem. Societ
filed in Hygin of the		17. Father's Name (First,						l .	s Name (First, Middl			
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	To Be	William Fra 19a Informant's Name/Re				19b Mailir	na Address (Str		thy Mariar			State Tie Code)
e, MD 21215-003 I and 2 should be filed within Health and Mental Hygiene, item 27 is marked other th	-	Michael				1			Rockville,			state, Zip Code)
e, MC I and 2 sl Health ar Titem 27		20a. Method of Disposition	n	_		lace of Dispo	sition (Name of c		Date			ty or Town, State
TOFE Pages I ent of H nt: If i		1 Burial 2 X Cr		Removal from Sta		ematory or o	inerplace) ln Crema	tory	Unknown	Bre	entwoo	d, MD
Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr		21. Signature of Funeral				22.			Simple I			-
		U/O &		,	10/46	_			e Pike, Ro			ID 20852
Physician /Medical		23a. Part I. Enter the dise failure. List only one	ase, or complicate cause on each l	tions that caused line.	the death.	Do not enter	the mode of dying	g, such as ca	ardiac or respiratory	arrest, sho	ck, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final or condition resulting in o					aumatic)	spler	nic ruptur	ce		Death
			, Duc	to (or as a conse	quence of)							
	Jer	Sequentially list condition if any, leading to immedia	ate Due	to (or as a conse	quence of)							
۵	Examiner	cause. Enter Underlying (Disease or injury that ini	tiated ^{C.} —	to (or as a conse	duence of)							
outed on transit		events resulting in death)	d.	10 (0. 00 0 00.00	4401100 017	•						
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760, cate be physicia	≥	IF FEMALE:	- 2	23c. If yes, outcom	e of pregn	ancy	9902 47	29/10	11	23d	Date of del	ivery
68 certifi nding ise as	ian	23b. Was decedent pregna past 12 months?	and in the	lLive birth pregnant at t	ime of dea	=		Ectopic	pregnancy	11	Month	Day Year
Box 687 ne death certific the attending I	Physician/	1 Yes 2 No 9	Unknown	Unknown		™ 5 <u> </u>	ther (Specify)					
P.O. I		Part II. Other significant	conditions cor	ntributing to death	but not res	sulting in the	underlying cause	given in Par	t I. 23e. Did	tobacco u	se contribut	e to the cause of death?
ires that the signed by	q p	Splenomega	aly; Hyp	ertensiv	e ath	erosc	lerotic		1 🗆 \	res 2	No 3	Probably 4 V Unknown
Division of Vital Records, P.O. I Hospital or Attending Physician: The law requires that the 24 hours after death, fracting and the frameral Director: After this certificate has been signed by the functal director, page 2 should be detached.	Completed by	_cardiova:	scular d	isease;	chror	ic act	tive hep	atitis	24a. Wa	as an topsy		e autopsy findings available to completion of cause of
tal Reco	шо		-						per	formed?	deat	
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n of ding Ph	.: 	27. Manner of Death 1 X Natural 5	7 - "	28a Date of Injur (Month, Day, Ye	y ear)	28b. Time of		ury at Work?		e how injur	y occurred	
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lospit 4 hour uners		4 Homicide 29a. Certifier 1 Certif			knowledge	doath coor	rrad at the time of	date and alo	ce, and due to the ca	uso(s) ond		atata d
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	one) 1 Certification Certifica	al Examiner: On	the basis of examed manner stated.	nination and	d/or investiga	ition, in my opinio	n, death occ	curred at the time, da	te and plac	e, and due t	to the cause(s)
	- €	29b. Signature and title of				_	29c Licen	se number	-	29d D	ate signed	(Month, Day, Year)
IREND	-	1.//										
HEND	<	MIL		7	M		O.C	.M.E.		Marc	h 9, 2010	0
HEND	~	30. Name and address of	person who conti						ro MD 24224	Marc	h 9, 2010	
(PEND		30. Name and address of Russell Alexando	person who controller MD. Ass	pleted cause of desistant Medica	al Exami	ner 111			re, MD 21201	Marc	h 9, 2010)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 3, Carl Junior Duvall [□]2^y010 7:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Sept. 16, 1930 1 ፟ M 2 □ Months Hours Min Maryland Director 215-26-9009 79 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 1XX Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I Hygiene. other than "natural", or items 23a Funeral 10 East 16th Street, Apt. 21701 United States death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 within 72 hours after If Yes, Give Korea Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk.) should be filed and Mental H is marked ot ည Elsie William Duvall ge 1 and 2 should be it of Health and Mer If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 East 16th St., Apt. 6, Frederick, MD 21701 Lena Duvall / Wife Baltimore, 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 20b. Place of Disposition (Name of 20c. Location - City or Town, State March Bat 8. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State cemetery, crematory or other place) any injury or 4 Donation Resthaven Crematory 2010 Frederick, Maryland Other (Specify) 21. Signatur Funeral Se ce Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease shock, or heart failure. e of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Approximate Interval Between Immediate Oduse (Final Onset and Death Pnysician/ Chronic Obstructive Lung Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of). resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 No signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> Records, 1 Yes 2 No 3 Probably 4 Unknown been sig Multiple Nodules in the Liver Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Who 24a. Was an Hypertension page 2 s autopsy performed certificate 2 1 Yes Division of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 2 🖳 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month. Day, Year) 08 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2411/4

Registrar

State

Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year eville ecelia Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MAIR 2/inton Huzz ta If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace Months 1 M 2 X F (Month, Day, Year 92 -58 Director Usual Residence of Decedent 23a or 28a-f show 10b. County 10c. City. Town or Location any injury or other traumatic event, the Medical Exeminer must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7606 USA 20772 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other than "natural", or items. 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖟 No Specify: If Yes, Give 3 M Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home make 12 Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ MAdovah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 7606 20772 permit. Page 1 and 2 Department of Health Important: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensed Name and Address of Facility MI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition) Medical resulting in death) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events Due to (or as a conseque resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a d be detached for 1 Yes 2 L 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autonsv performed? Yes 2 100 death? 1 Yes 2 No 25. Was case referred to medical Division of Vital To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner's 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work?
1 Yes 2 No of Funeral Director: Aft bleted filled in by the fur Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location /Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and address cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Rummond 14:17 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death inton MI HUSpita Prince Geurge Social Security Numb 6. Sex Age (In yrs. last birthday) if Under Year If Under 24 Hrs. Date of Birtin (Month, Day, Year) 9. Birthplace State or Foreign 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min Director 40 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marzyland 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9505 USA 20735 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married δ within 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🗷 No Specify: 3 🗌 Widowed 4 🔲 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Photograher 12 polyec Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pineview Mother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) /4 21. Signature of Funeral Service Licensee 20608 22. Name and Address of Facility MI 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami attending physician and for use as the bunal-transit The law requires that the death certificate be executed resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the a g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform Yes 2 of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗔 ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner A Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. edical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Certifying Nurse 29b. Signature Name and address of p e of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Capies Are Legible.
Amend Item 24a per phys. G903 3/19/10 ak
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ckett -AKISOW 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3622 1 Temple 17/113 rince iron 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Yrs 579-50-3312 Director Marzyland 19:30 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 200.00. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Director Hills Maryland Prince 10e. Street and Number 10f Zip Code 10g Citizen of What Country? 3622 USA Funeral 20748 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ∐Yes 2 [X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify. ρ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) hawson ပ ines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ä 3622 S MI e IXOM 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State MI 4 ☐ Donation 5 ☐ Other (Specify) rection 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams MO1589 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due as a consequence of): pertensive CARDIOVASULAR /Medical Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for t in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 💆 Residence 6 Nother (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 □Yes 2 □No hours after death uneral Director; 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road 9001 Wood Henry 20735 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 12, Day Otis Leroy Davis Jr. 2010 0022 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days 215-62-2129 54 0211311956 Maryland Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In terms 27 is marked other than "natural", or items 23a or 28a-f shor lury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 Delaware Ave. 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. black þ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates and Mental Hygiene.
is marked other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) laborer none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Otis Leroy Davis Sr. Roxie Cuff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Delaware Ave., Salisbury, MD 21801 Hope Davis/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of half Important: If ite any injury or other Date 20c. Location - City or Town, State Stemetary Cremata Me Sterolage Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spenify) 3 20 2010 Laurel, DE 21. Signature of Funeral Service Stewart drumeray Home 821 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only of cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2 s performed ☐ Yes 2 ☐ 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours and To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

The

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day Year **Physician** 00.0010 1050 PM 2016 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NMS Healthcare Washington Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 ☐ F Oct. 9, 81 1928 Director 220-30-9926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21783 21216 Chewsville U.S.A. death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygiens Important: If Item 27 is marked other tha any Injury or other traumatic event, the 1 once. 12 Dairy Farmer **Agriculture** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Grimm Birdie Monger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance J. Grimm / Wife 21216 Chewsville Rd. Smithsburg Maryland 21783 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory 3/18/2010 Smithsburg Maryland 5 ☐ Other (Specify) 4 □ Donation 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** C. nsuns /Medical Due to (or as a consequence of): Examiner mentio Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Does to for as a consequence of) Examiner death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physiclan Physician/Medical the IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ρ in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate Division or Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 27. Manner of Death 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pin 24 hours after death. 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 💢 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

phenic

31. Date filed (Month, Day, Year) 32. Registy s Signature MAR 24 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

one

Mush Pike

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}2010 Francis Eugene Heise March 5 A M 4:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Frederick Mount Airy . Social Security Number 8. Date of Birth (Month, Day, Year) March 13, 1930 Maryland If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 X M 2 | F **Director** 218-26-3703 79 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Frederick Rocky Ridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9201 Longs Mill Road 21778 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Mamed 2 Married δ 1 ☒ Yes 2 ☐ No 1952— If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: Completed 3 🗆 Widowed 4 🗆 Divorced Specify: White 1955 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Mediconce. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Project Manager Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Randolph Heise Elizabeth Wintz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Lee Heise / Wife 9201 Longs Mill Rd., Rocky Ridge, MD 21778 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 5 Retart haven Memorial Gardens 1 😾 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Frederick, Maryland 21. Signature neral Service Licensee 22 Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease shock, or heart failure. L Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between only one cause on each line Onset and Death Pnysician/ Adenocarcinoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy death? certificate 1 🗌 Yes 2 🔀 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 XNo 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA hospice 24 hours after death.
Funeral Director: After this eted filled in by the funeral di 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Investigation
6 Could not be 2 Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3-5-10 31058

State Registrar

AULTOI

Ashe, M.D. 10200 Coppermine Rd., Woodsboro, MD 21794

Butal

32. Registrar's Signature

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 3/8/2010 Year Kathleen Horay 11:05 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10120 North Ave. Ocean City Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 **X** F Days 2/29/64 Year) Hours Min. 46 Washington D.C. Director 217-96-6631 Usual Residence of Decedent Show 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f st notified MD 1 Yes 2 No Worcester Ocean City 10e. Street and Number ritems 23a or ner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 10120 North Ave. 21842 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc "natural", or i edical Examin 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify: White 1 Tes 2 X No Specify 3X Widowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Ē electrician self-employed Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed thent of Health and Mental H rtant; If item 27 is marked of njury or other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) John M. Maphis Elizabeth Bierwirth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Maphis/father 10120 North Ave., Ocean CIty, MD 21842 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or 3/10/2010 |Frankford DE 4 Donation 5 Other (Specify) Cape Henlopen Crem. . Signatur of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD. 21811 23a. Par 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Uniderlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year 1 | Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ ک 2 No Completed 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform death? 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be

Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death.

Funeral Director: After this ted filled in by the funeral d To the Hospital within 24 hours a To the Funeral I

3 Suicide

4 Homicide

determined

Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 0 2010	Kel	
BAY		30 Name and address of person who completed cause of glath (Item 23a) (Type, Print) David Covall, ND Coxytal Hospic F	20 Box 1733 Salve	L MD 21802
To t with To t		29b. Signature and title of certifier	29c. License number	3 - 9 - 10
he Hos in 24 h he Fun ipleted	Medi	(Check Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		Plea . For	ase Type or Pri State of M				. Ensure A Health and I		_	ible.	00001		
		- State Registrar			Cei	tificate of	Death		Reg. No.	JIU	13001		
Physicia		1. Decedent's Name (First, Midd MARY EVELYN BR.						2. Date of Domestry MARCH		010°	3. Time of Death 2:00 P M		
/Medica Examine		4a. Facility Name (If not institution RESIDENCE. 930)	on, give street and number,			4b. City, Town, or CLINT(r Location of Death		4c. Coun	ty of Death			
Funeral Director		5. Social Security Number 577–24–2485	ge (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.				place (State or Foreign			
and and		Usual Residence of Decedent 10a. State 10b. County	/	10c. City.	Town or Lo	cation				1	Od. Inside City Limits		
Maryl a-f sho	ģ	MARYLAND PRINCE		CLIN							1 XYes 2 □ No		
th with the 23a or 28	al Director	10e. Street and Number 9303 PELLA STR			10f. Zip Code 2073	35		10g. Citizen of UNITED	-				
urs a	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	Ever in U.S. No	1	Was Decedent of H f Yes, specify Cuba I □Yes 2 No	lispanic Origin? (Si an, Mexican, Puerti Specify:	pecify Yes or N o Rican, etc.)	o- 14. Ra Bl	ace - Americack, White,	etc.			
72 ho "natur	eted	15. Decede (Specify only highe	nt's Education est grade completed)	1	16a. Deced	dent's Usual Occup	pation during most of world)	king	16b. Kind of I	Business/In	dustry		
within jiene. r than	Completed	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or	5+)		RENCY COU			FEDERA	L GOV	ERNMENT		
uld be filed Mental Hyg rked other	To Be C	17. Father's Name (First, Middle ROBERT CLINTON			-		18. Mother's Nam		e, Maiden Surna	me)			
and 2 shoi ealth and ? m 27 Is ma ner trauma		19a. Informant's Name/Relation DORIS M. YOUNG				-	and Number or Ru VENUE, CL				735		
Pages 1. nent of Hi ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (-		cer	netery, cren	sition (Name of natory or other place ES CEMETI		Date 10, 2010	20c. Location				
permit. Departr Imports any inje		21. Stenature of Funeral Service	14 Will you	0583	TH 34	Name and Addre IORNTON F 39 LIVIN(ss of Facility UNERAL HO GSTON ROA	OME, P.A	A. AN HEAD	. MAR	YLAND 20640		
Physician and phisper street pe executed by Medical Examiner street burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
e death certif the attending ned for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify) ☐								23d. Date of delivery Month Day Year			
w requires thet the been signed by should be detach	by Pr	Part II. Other significant condit	ions contributing to death t	out not result	ing in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?		
require een sk	ted							1 🗆	Yes 2 No	3 ☐ Prol	bably 4X Unknown		
The ate h	Completed							24a. Was auto perf 1 □ Yes		. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of 2 No		
Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ient 2 🗆 Ei	R/Outnatier	t 3 DOA Oth	26. Place of Dea	, ,	one) sidence 6 □0	ther (C-sei	4.1		
ding Phys h. After this funeral dir	on: T	27. Manner of Death 1 ♣Natural 5 ☐ Pendi	28a. Date of Inj	ury 2	8b. Time of Injury				how injury occu		TY)		
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification: To		not be 28e. Place of In	jury - At hom tc. <i>(Specify)</i>	e, farm, str		Yes 2 □No		(Street and Nuπ own, State)	ber or Rura	al Route Number,		
Hospital	Medical Ce	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the best Examiner: On the basis and manner s	of examination	edge, death on and/or in	n occurred at the till vestigation, in my o	me, date and place opinion, death occu	e, and due to the	e cause(s) and o	manner as s	stated. o the cause(s)		
To the within To the comple	Me	29b. Signature and title of certific	/	D		29c. Licens	e number	99	29d. Date sign				
BB5		30. Name and address of person MANISHA JARIWAI	who completed cause of	death (Item 2	23a) (Type,	Print) 11637	TERRACE	SU	ITE 103				
Stat Registra	-	31. Date filed (Month, Day, Year) 20 Propint	rar's Signatu	9. 6			,					
100	04	44684											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Dep	ertificate of Death			2010	09082		
	Physici	an	1. Decedent's Name (First, Middle, Last)		2.	Date of Death Month	Day Year	3. Time of Death		
	/Medic		Ruby Lucille Hornbeak		Ma	arch	4, 2010	2:40A M		
	Examin		4a. Facility Name (If not institution, give street and number)	4b, City, Town, or Location	n of Death		4c. County of Death			
1			7655 Bensville Road	Waldorf	04 !! ! -		Charles			
	Funeral		5. Social Security Number 6. Sex 1 M 2 X F	If Under 1 Year If Under 1 Months Days Hours	s Min.	Date of Birth (Month, Day, Y		place (State or Foreign intry)		
	Director		579-05-1300 91 Yrs. Usual Residence of Decedent		Octo	per 9,19	918 Ma	ryland		
	dand ow		10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits		
	Mary -f sh	to	MD Charles Waldorf					1 □Yes 2X No		
	r 28a	Director	10e. Street and Number	10f. Zip Code		10g	J. Citizen of What Cou	intry?		
	h with		7655 B@nsville Road	20603			USA			
	deat r.ms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic C If Yes, specify Cuban, Mexico	Origin? (Specify	y Yes or No-	14. Race - Amer			
36	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Exavitrer must be notified at	by Fu	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specif		an, etc.)	Black, White	etc. ite		
21215-0036	thou attura	pe		edent's Usual Occupation		16	ib. Kind of Business/li	ndustry		
7	within 72 lene. than "nat	Completed	(Specify only highest grade completed) (Giv	e kind of work done during mo DO NOT use retired)	ost of working			,		
2	d with giene giene	mo:	Elementary/Secondary (0-12) College (1-4or 5+)	Clerk			Railroad			
פ	al Hygi other vent, II	Be C	17. Father's Name (First, Middle, Last)		ther's Name (F.	irst, Middle, Ma				
<u>a</u>	should be nd Mental marked o	To E	Thomas Wallace Bowling	Dai	sy Mari	le Simps	son			
Maryland	2 should and Men is marke		I = I	ing Address (Street and Num				ip Code)		
	s 1 and 2 should of Health and Mer Item 27 is marke other traumatic		Carl Hornbeak/Son 7655	Bensville Ro	ad, Wal	dorf,M	20603			
ore	0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition	osition (Name of ematory or other place)	Date	20	c. Location - City or T	own, State		
Ĕ	it. Pages rtment of rtant: If It njury or o		I I DUDUNAL Z LI CHEMALIUM S LI HEMUVAL MOM STALE I	coln Cemetery	3/8/20)10 вј	ladensburg	, MD		
Baltimore,	permit. Page Department Important: I any Injury o		21. Signature Litureral Service Licensee M00945	2. Name and Address of Faci AREHART-ECHOL	S FUNER	RAL HOME	E,P.A.			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en					4.6 pproximate		
			snock, or neart failure. List only one cause on each line.		1			Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	07 /	and	26	ee.			
	Examiner		Due to (or as a consequence of):							
		-	Sequentially list conditions, b. Due to lorge a nonaculance fire							
	nsit	nin	cause. Enter Underlying Cause (Disease or injury							
	execu n and al-tra	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):							
68760,	tificate be executed g physician and as the burial-transit	cal	d							
9	tificat ng phy as the	edical								
Box		2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of deli	very		
	requires that the death cer seen signed by the attendir nould be detached for use	Physician/M	1 Ves 2 No. 4 Pregnant at time of death 5	□ Ectopic pregnancy □ Other (s <i>pecify)</i>			Month	Day Year		
<u>Ч</u>	tt the by th tache	hys	9 ☐ Unknown							
	w requires that the di been signed by the should be detached	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part	t I.	23e. Did tobac	cco use contribute to	the cause of death?		
Records,	equire sen si outd b	pe				1 □ Yes	2 □ No 3 □ Pro	bably 4 🗌 Unknown		
ပ္ပ		Completed				24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of		
	sician: The law certificate has b irector, page 2 sl	E O				performe	d2 death? ¶No 1 ☐ Yes	•		
Vital	slan: ertific ctor,	Be (25. Was case referred to medical examiner?	26. Pla	ice of Death (C	-	(
	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 1	Nursing Home	5 Residence	ce 6 Other (Spec	ify)		
<u>د</u>	ding Physician: h. After this certific funeral director,		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at Work?	28d	. Describe how	injury occurred			
<u> </u>	Attending r death. sctor: After by the funer	cati	2 Accident investigation	M 1 ☐Yes 2 [□No					
Division of	pital or Attenctours after deatheral Director:	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s' building, etc. (Specify)	reet, factory, office	28f.	Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,		
	pita ours eral fille		29a. Certifier (Check only 2 Medical Examiner: On the best of my knowledge, dea	th occurred at the time, date	and place, and	I due to the cau	ise(s) and manner as	stated.		
	To the Hos within 24 h To the Fun completely	ledical	one) and manner stated.							
	Not to the state of the state o	Σ	29b. Signature and title of certifier	29c. License number		29d	Date signed (Month	, Day, Year)		
			Kildh	1028 3	5/ 7		5/5/10			
	886		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) > X 170 3	3 6	Plate	MI	7066		
	Sta		31. Date filed (Month, Day, Year) NAR 0 8 2010 32. Registrar's Signature	the d			- (
	Registra	ग	MAIL O COLO LANDE S. FRE	Bridge.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Anna R. Hickey March (c, 2010 0020 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Rehabilitation + Nursing Ctr. 5. Social Security Number 6. Sex 17. Age (In vis. Idan hirthday Wicomica 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min. 06 14 1920 1 ☐ M 2 🛣 F Months Days Hours 170-91-4064 89 Director Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County show ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 X Yes 2 No Director Salisbury Maryland Wicomico 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 200 Civic Ave. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Hnna Hickey Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: white Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "n any Injury or other traumatic event, Ite Mana once. Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Gallagher Anna Struck ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Schaeffer/daughter 25330 Fareway Dr., Quantico, MD 21856 20b. Place of Disposition (Name of cemetery, crematory or other properties of the pr 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3 11 10 Bushnell, FL 4 ☐ Donation 5 ☐ Other (Specify) 2HOTTOWAY Funeral Home Professional Association 21. Signa Que of Funeral Service Licen 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that cuse, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest encoded, or heart failure. List only one cause control is control in the death. Immediate Cause (Final disease or condition resulting in death) **Physician** 10 9 al /Medical Due (or as cons ence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami signed by the attending physician and I be detached for use es the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 ficate has been sign, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy certificate l 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1€10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Anatural within 24 hours arter voc...
To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 10

dilliam

H.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Robins

DHMH 17 Rev 1/2001

Back

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29c. License number

Ave. Sa

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 -08 - 2010 Physician/ Fooks Hill Joanne 01:55A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death lisbun Willomico pice @ the ake If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Days Hours 09 22 Country)
Maryland 214-42-8951 66 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 V No Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral hours after death with 7579 Esham Road 21849 USA items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11 Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 6 þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give white 'natural", 3 M Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene, important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 12 housewife domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josiah Washington Fooks Ida Mae Adams 19a Informant's Name/Relationship (Type, Print)
Susan M. Bishop|personal rep 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Codel 33573 Dublin Rd., Princess Anne, MD 21853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Springhrilly Memory 1 X Burial 2 Cremation 3 Removal from State 3 | 11 | 2010 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) HOITOWAY Funeral Home Professional Association T 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final melas Physician/ ancel disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed Yes 2/L 2/1 No 1 Yes Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: HOSDICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No □ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3/ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

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30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

10

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 5 per fh g902 4-13-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elaine Hall Donna 9835 M MARCH 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death HICUMIE 3043640 Age (In yrs. last If Under 1 Year If Under 24 Ars 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛂 F Months Davs Hours Min. (Month, Day, Year) 06 | 19 | 1935 Country) Colorado Director 521-38-5460 Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏻 No Delaware Sussex Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19956 USA 12212 Trussum Pond Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian or. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) nursing assistant health care Be 18. Mother's Name (First, Middle, Maiden Surname)
Marjorie Welch 17. Father's Name (First, Middle, Last) ည Donald Lane Adams 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 12212 Trussum Pond Rd., Laurel, DE 19956 Edward Hall/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 and Department of F Wicomico Memorial Park any injury or 1 Burial 2 Cremation 3 Removal from State 3|9|10 Salisbury, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Holloways Funeral Home, Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) COPD Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law raquires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral idirector, p. ge 2 should be detached for use as the burial-transit the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) a No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 Tes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 102ab D68222 03/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salishury MD 2180 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 0 0 0 0 0

		-	State Registrar			•	Ce	ertificate of i	Death			Reg. No.	201	U	090	100
	Discolate	,	1. Decedent's Name (First, Mic	ldle, Las	st)						2. Date of Dea	ath			3. Time of D	eath
	Physicia Medic				TRUDY	ELIZA	BETH	HILL				18	201	o	4:23	Αм
	Examin		4a. Facility Name (if not institut	ion, give	street and number)		4b. City, Town, c	r Location	of Death		4c.	County of De	eath		
-A				Frederick Memorial Hospital						Frederick				ick		
	Funeral Director		5. Social Security Number 212-62-3383	6. S	ex 7	Age (In yrs. 55	Ast birthday, Yrs.	Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Birl 4-2-19			Birthpla Countr	ace (State or I	Foreign
	lt o		Usual Residence of Decedent 10a, State 10b, Cour	ntr.		10- 0	ty, Town or L							Lie		
-	rylan *f sh led a	용		,	,									10	d. Inside City	
:	e Ma r 28a notifi	Ę.	MD Fred 10e. Street and Number	eric	ck		Freder								1 🗆 Yes 2	2 Las No
:	th th	Funeral Director		я .				10f. Zip Code					izen of What (Count	ry?	
	ms 2	au l	54 South Pend	Letc	on Court 12. Was Deceder	at Cuar in 11	c 112	. Was Decedent of F		rigin? (Cnoo	ify Voc or No	<u>US</u>			1	
	or ite	by F	1 Never Married 2 N	//arried	Armed Force	s?	.5.	If Yes, specify Cub					14. Race - An Black, Wh			
ي ک	rsafte ral", Exar		3 Widowed 4 💆 Divord		If Yes, Give Year or Dates			1 ☐ Yes 2 🛛 No	Specify	y:			Specify: Wh	nit	e	
0500-c	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important if firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Dece (Specify only hi		ducation ade completed)			edent's Usual Occup kind of work done		st of workin	a	16b. Ki	ind of Busines	ss Indu	ıstry	
<u> </u>	than than	ĕ	Elementary/Seconday (0-12		College (1-4 o	or 5+)	life.	DO NOT use retired,)		,	<u></u>		7.1		
7	Hygie Hygie other int, th	as l	17. Father's Name (First, Middl	a Last)			1 Tec	hnician	10 14-41	barda Marra	(First, Middle,	_	outer S	SC1	ence	
yland	be file	2	John Edward C		ford Sr				l		ane Rey		,			
<u> </u>	ould nd Me s mar smarti		19a. Informant's Name/Relation				19b. Mai	ling Address (Street						Zin Co	nde)	
Ma	d 2 st alth a 27 is		Michael Hill		Son			South Pend							,	
e e	1 and 1 and 27 Height		20a. Method of Disposition				Place of Disp	oosition (Name of ematory or other pla	00)	Da	ate	20c. Lc	ocation - City	or Tow	n, State	_
<u> </u>	Page nent ant: If ury or		1 ☑ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe			110		ivet Cem.		3-23-2	2010	Fred	derick.	. M	arvlan	d -
baitimoi	permit. Departr Importa any inju		21. Signature of Funeral Service	e Licen	4/	\		22. Name and Addre								
1	<u>ಹರಕ ಕರ</u>		Mar	N	More	/M011		.06 East (ick, M	2	1701	
			23. Part 1. Enter the disease shock or heart failure. Li				th. Do not er	iter the mode of dyir	ng, such as	s cardiac or	respiratory an	rest,			Approximate Interval Betwe	
P	h sician/		Immediate Cause (Final disease or condition		a Po	eun	~~	ı						1	Onset and De	eath
1	Medical Examiner		resulting in death)	•	Due to (or	as a conseq	(uence of):									
		ē	Sequentially list conditions, if any, leading to immediate		b. Due to (or :	as a consec	ulence off:							+		
7	red	Examiner	cause. Enter Underlying Cause (Disease of Illijury	<	240 10 (01	ao a oonoo	(delibe 01).									
0	n and al-tra	Exa	that initiated events resulting in death) Last		Due to (or a	as a consec	quence of):							\top		
2	cate be executed physician and the burial-transit	Medical		L	d											
0/0	ing ph	Med	IF FEMALE:									- 1				
Š	r use	_	23b. Was decedent pregnant in the past 12 mg/nths?		23c. If yes, outcor	ne of pregn	ancy tal death 3	☐ Ectopic pregnan	CV				23d. Date of	deliver	у	
POX	To the bropping or Attending Prhysicians: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within Earland Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4 ☐ Pregnar 9 ☐ Unknow		death 5	Other (specify)					Month		Day Ye	ar
5	ar the od by detacl	, Ph	Part II. Other significant cond	ditions c	ontributing to deat	h but not re	sulting in the	underlying cause g	iven in Par	t I.	23e, Did to	obacco u	se contribute	to the	cause of dea	ath?
S,	signe d be	d b	Cardiopal	mo	many F	hre	st				1 🗆	Yes 2	□ No 3 □	Proba	ably 4 🗹 Ui	nknown
ם	requ been shoul	lete	5-613,000	No		a.	0.0	Aprec			24a, Was	an	24b. Were	autons	sv findings av	ailable
Vital Records,	e has	Juc	Ataile	-1	11 2	31.6	ecp i	TPNEC			auto	psy ormed?	death	?	sy findings av upletion of cau	use of
I A	in: Ir tificat or, pa	Be C	25. Was case referred to media	cal	llanon			26 F	lace of De	ath (Check	1 Yes	2 № No	1 1 1	res 2	2 □ No	
VIT	ysicis is cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	- 27	Hospital:	atient 2 🗆	BR/Outpati	ent 3 DOA Oth	ner:	1.00	ne 5 🗆 Resid	dence 6	Other (So	ecify)		
5	ig Pro ter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Per		28a. Date of i		28b. Time injury		ry at		8d. Describe h					
	renair leath. or: Af the fu	ifica		estigation	n			M 1 🗆	Yes 2	□No						
DIVISION OF	or Att after d Direct in by	Certificate:		ermined	28e. Place of	Injury - At h etc. <i>(</i> Spec <i>it</i>	ome, farm, s fy)	treet, factory, office		2	8f. Location (9 City or Tow			Ru <i>ral F</i>	Route Numbe	r,
ב ב	ours ours ours ours ours ours ours		29a. Certifier 1 Certify	ring Phy	rsician: To the best	of my knov	vledne death	occured at the time	a date and	t place, and	due to the ca	uso(s) an	d manner as	etated		
-	e Hove 24 h e Fur e Fur	Medical	Check 2 ∟ Medic	al Exam	iner: On the basis o	of examination	on and/or inve	estigation, in my opin , death occurred at the	ion, death o	occurred at t	he time, date a	and place	 and due to th 	ne caus	se(s) and mann	ner stated.
i i	lo th withir To th comp	~	29b. Signature and title of cert	-	1/		,	29c. Licens	e number			29d. Dat	te signed (Mo.			
			1	//	/ 1	Kr		D	666	510		-4	2 - i 8	5 -	2010	
			30. Name and address of pers			,	, , , , ,	Print)	_	1.	10 21					
			Surendra Manth Day You				7th S.	t. Fred	eric	K, n	10 21	70	\			
	Stat Registra		31. Date filed (Month, Day, Yea	24	2010 32. Hear	strar's Signa	ature	barres								

Physici /Medic Examin

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 10

Division of Vital Records, P.O. Box 68760,

		1 - State Registrar	Certificate of Death Reg. No 2010 09087
sicia	n	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 5. 0.0 0 M
dic	al	4a. Facility Name (If not institution, give street and number)	Jackson March 07 2010 5:20 P.M. 4b. City, Town, or Location of Death 4c. County of Death
mine	∌r	The Johns Hopkins Hospital	Baltimore City
al		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) Country)
or		219-44-9608 XX ^M 2 F 63	June 14, 1946 Maryland
	_	10a. State 10b. County 10c. City, Town	
	Director	Maryland Cecil	Elkton 1 ☐ Yes 2X No
	ă	10e. Street and Number 67 Kimberly Circle	10g. Citizen of What Country? 21921 U.S.A.
	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-
	<u>۾</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify: Black, White, etc. Specify: White
	eted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use artifact) OCT Use artifact) OCT Use artifact)
	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Eight Years Ju	udge of the Circuit Court Elkton, Maryland
	BeC		18. Mother's Name (First, Middle, Maiden Surname)
	은	Absolam Dunbar Jackson	Isabelle Lee Watson
			Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Circle, Elkton, Maryland 21921
1		20a. Method of Disposition 20b. Place of	Disposition (Name of Date 20c. Location - City or Town, State
		4 Donation 5 Other (Specify)	rris & Colnc. 03/13/2010 Pennsylvania
ouce.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766
		23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	
n		Immediate Cause (Final disease or condition	Versus Host discuse Onset and Death
al er		resulting in death) Due to (or as a consequence of	νη:
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	yoloid lenkemia
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.	· ·
			ንፃ:
	Medical	d	
	~~~	11 1 2147/122	23d. Date of delivery
	sicie	in the past 12 months?  1	3
	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
	Completed by Physician		1 □ Yes → No 3 □ Probably 4 □ Unknown
1	plete		24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
	E O		performed?   death?   1   Yes 2   No
d	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
	<u>۾</u>	27. Manner of Death 28a. Date of Injury 28b. T	Firme of 28c. Injury at 28d. Describe how injury occurred
	atio	2 Accident investigation	njury Work? M 1 Yes 2 No
	ertific	3 Suicide 6 Could not be determined 28e. Place of injury - At home, far building, etc. (Specify)	rm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	edical Certification:	29a. Certifier (check onl) 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	Me		29c. License number 29d. Date signed (Month, Day, Year)
		1 100	KES-000   March 07 2010
		30. Name and address of ferson who completed cause of death (Item 23a)	(Type, Print) 600 North Wolfe St, Baltimore, MD, 21287
Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
istra		MAR 11 2010 Janua &	· par
1/20	10	,	

DHMH 17 Rev 1/2001

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 4. 2010 CALVIN JOHNSON, SR. 11:25A ^M la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES CENTER CHEVERLY PRINCE GEORGES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Days 1 🛛 M 2 🗆 F Months Hours 439-36-6432 LOUISIANA Yrs. 82 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 🗌 No PRINCE GEORGES LARGO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 LARGO ROAD 20774 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 △ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SECURITY GUARD FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRIETTA HARRELL WILBUR JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CALVINA D. PAGE/DAUGHTER 8702 LOLLY LANE, CLINTON, MARYLAND 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MD VEIERANS CEMETERY 03/23/2010 CHELTENHAM, MARYLAND

HOME,

HEAD. MD 20640

29d. Date signed (Month, Day, Year)

Belle Pt DR Greenbelt, MD 20770

2010

Approximate Onset and Death

Physician/

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f shov edical Examiner must be notified at

the Medical

I Hygiene.

permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical

10a. State

MD

Director

Funeral

<u>Ş</u>

Completed

Be

မ

Signature of Funeral Service

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Meki

LYDIA C. THORNTON JOHNSON MO0583

Physician Medical **Examiner** 

signed by the attending physician and d be detached for use as the burial-transit that the death certificate be executed

has

funeral director,

within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

thin 24 hours at

Division of Vital Records, P.O. Box 68760

Physician/Medical Examine Completed by To Be

	Immediate Cause (Final disease or condition resulting in death)	Fatal Cardiac Arry thmia		Onset and Death
Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Sepsis  Due to (or as a consequence of):  Congestive Heart Failure  Due to (or as a consequence of):		
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	c. If yes, outcome of pregnancy  1	23d. Date of d Month	elivery Day Year
Completed by Pl	Part II. Other significant conditions cont Hypertensio Prostate Can	ributing to death but not resulting in the underlying cause given in Part I.	autopsy prior to	Probably 4 Unknown utopsy findings available
Be C	25. Was case referred to medical examiner?	26. Place of Death (Checi		es 2 🗆 No
2	1 Yes 2 No		ome 5 Residence 6 Other (Spe	cify)
ficate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)  28b. Time of 28c. Injury at work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
al Certi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Ri City or Town, State)	ural Route Number,
Medical Certificate:	(Check 2 Medical Examine	ian: To the best of my knowledge, death occured at the time, date and place, and on the basis of examination and/or investigation, in my opinion, death occurred at Practioner: To the best of my knowledge, death occurred at the time, date and place.	t the time, date and place, and due to the	cause(s) and manner stated

MO

Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

DHMH 17 Rev 7/2009

State Registrar 1705

29c. License number

D0062116

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State o	f Marylan	-	artment of tificate of	10 0908	3 9			
	Dii-i-	/	Decedent's Name (First, Middle)	, Last)					2. Date of De		3. Time of Death	1
	Physicia Medic		CHARLES	Α.		JOHNST	ON		Month 0.3		620 17:25 P	М
فر	Examin	er	4a. Facility Name (if not institution, PININSUM Reg.		d ICAL	CANTU	4b. City, Town,	or Location of De	ath	4c. County of	Death *	
	Funeral Director				7. Age (In yrs. Ia 76		If Under 1 Year Months Days			th ay, Year) 8, 1933 P.	9. Birthplace (State or Fore Country) ENNSYLVANIA	ign
_			Usual Residence of Decedent  10a. State 10b. County		10.00				DOME 2	<u> </u>		$\equiv$
	aryland a-f sh fied a	Funeral Director		MICO		y, Town or Loc WILLAR					10d. Inside City Lim	
	or 28	Dir.	10e. Street and Number	11100		WILLIAM	10f. Zip Code		_	10g. Citizen of Wh		-
	s 23a ust b	era	7293 JAKE STR	EET			2187	74		USA		
	death r item iner m		11. Marital Status	Armed For			Vas Decedent of I f Yes, specify Cub	Hispanic Origin? Dan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	1.11.11000	American Indian, White, etc.	
036	o filed within 72 hours after death with the Maryland Hygiene.  Hygiene.  do other than "natural", or items 23a or 28a-f show to other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at.	ed by	1 ☐ Never Married 2 🛛 Marr 3 ☐ Widowed 4 ☐ Divorced	If Von Cive	2 □ No e tes. 1953-	.56	☐ Yes 2X N	o Specify:		Specify:	WHITE	
21215-0036	hour "natur	Completed		it's Education		16a. Deced	lent's Usual Occu	pation	vorkina	16b. Kind of Busi		$\dashv$
121	thin 72 ane. than he Me	Com	Elementary/Seconday (0-12)	College (1-	-4 or 5+)	life. D	O NOT use retired	)	VOLKING	CIFANING	G SERVICE	
92	lled wi I Hygie other ent, tl	Be	12 17. Father's Name (First, Middle, L	ast)		I OMI	EK/OFEK		Name (First, Middle	, Maiden Surname)	3 DERVICE	$\dashv$
Maryland		욘	NORMAN	Α.	JOHNSTO	N		RUBY	W	ARDEN		
Mar		93	19a. Informant's Name/Relationsh			1				er, City or Town, Sta		
	and Heal tem		ALICE D. JOHNST  20a. Method of Disposition	ON/WIFE	20b. F		JAKE STE sition (Name of	REET, WI.	LLARDS, I	ARYLAND 2	21874 lity or Town, State	-
altimore,			1 X Burial 2 ☐ Cremation 4 ☐ Panation 5 ☐ Other (S			-	natory or other pla ANS CEME	- 1	/11/10		MARYLAND	
3alti	permit. Page Department of Important: If any injury of once.		21. Si matur de Fune dal Service L	to see		22	. Name and Addr	ess of Facility				$\neg$
m	<u></u> <u> </u>	11	23a. Part 1. Enter the disease, or	Thu							DE. 19975	-1
	Ph sician/		shock, or heart failure. List o	nly one cause on ea	ch line.	n. Do not ente		mg, such as card	ac or respiratory a	ACCO A	Approximate Interval Between Ogsel an De th	
	Medical Examiner		disease or condition resulting in death)	a. Due to (	or as a consequ	uence of):	1001	vmorg	un	my w.	4 yx	4
		eľ	Sequentially list conditions,	b. — Durate (								
	ted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (	or as a consequ	derice oi).						
	execu an and rial-tra	I Ex	that initiated events resulting in death) Last	C. Due to (	or as a consequ	uence of):						
90	cate be executed physician and the burial-transit	edical		d								-
687	certific nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	incy				23d Date	of delivery	
30X	death of atter	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		Birth 2  Feta nant at time of o		Ectopic pregnar Other (specify)	ncy		Mont		
0	at the c d by th etache	Phy	9 Unknown  Part II. Other significant condition			sulting in the u	inderlying cause o	iiven in Part I	00 - Did		ute to the cause of death?	
Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Atter this certificate has been signed by the attending physician and male funeral Director, page 2 should be detached for use as the burial-transit	d by	- are in our or	nio contributing to di	out i but not roo	alting in the c	indonying dadoo g	ivon in raici.	1		Probably 4 Unkno	
ord	w requ	plete							24a. Was		ere autopsy findings availab	ole
Rec	The lav ate has page 2	Completed							— auto	ormed? de	or to completion of cause of ath? □ Yes 2 □ No	of ]
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Place of Death (C				
<u></u>	Physic r this c eral dir	e: To	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2  of injury	ER/Outpatier 28b. Time of	it 3 🗆 DOA			idence 6 Other	(Specify)	
ou	arth. r: Afte	icat	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident Investiç	gation	th, Day, Year)	injury	wo	rk? ] Yes 2 ☐ No	200. 50001150	now injury occurred		
Division of Vital	or Atte ifter de Sirecto in by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place	of Injury - At ho	ome, farm, str	eet, factory, office		28f. Location City or To		or Rural Route Number,	
Ξ	spital		29a. Certifier 1 Certifying	Physician: To the b	est of my know	ledge, death of	occured at the tim	e. date and place	e, and due to the c	ause(s) and manner	as stated.	-
	he Ho iin 24 h he Fui	Medical	(Check 2 🖳 Medical E	xaminer: On the bas Nurse Practioner:	is of examination	n and/or inves	tigation, in my opir	ion, death occurre	ed at the time, date	and place, and due to	o the cause(s) and manner s	tated.
	P P P P		29b. Signature and title occurifier	10000			29c. Licen	se number		29d. Date signed (	Month, Day, Year)	
	Or VI		30. Name and address of person v	who completed assis	e of death (Itan	23a) /Time F	Print)	2050	)	0///(	0	
	- Nd		Tosenh M.	UR NS.	S O 1	00 E	CARR	066 St	SAU	spany	m)	
	Star Registra		31. Date filed (Morkly, Pay Year)	2010 32/2	egistrar's Signa	turg. So	we					

			1 - State Registrar	State of Marylan	-	artment o rtificate			d Mer	_	giene Reg. No	20	10	09090
	Physici	an	1. Decedent's Name (First, Middle, Last)							Date of De Month	ath Day	,	Year	3. Time of Death
	/Medic		Kathleen Marie						M	arch		2010		9:57 PM M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Tow		ation of De	ath		4c.	County	of Death	
-			3605 Forest View			Waldo:		H=d== 04 H				arle	es Co	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Y		Under 24 H lours Mi	in.	Date of Bir (Month, Da	ay, Year)		Cour	
	Director		230-16-8200 Usual Residence of Decedent	86					Jи	1y 10	1,192	23 N	/irgi	nia
	land ow		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation							1	0d. Inside City Limits
	Mary f sh	ţ	MD. Charles C	ounty Uni	ldorf									1 <b>X</b> Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	Ouncy was	LUOII	10f. Zip Co	de				10g. Cit	izen of W	/hat Coun	itry?
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	<u>a</u>	3605 Forest View	Dr.		2060	1				Unit	ed S	State	es.
	deatl	Funeral		2. Was Decedent Ever in U	.S. 13.	Was Decedent If Yes, specify		nic Origin?	(Specify			14. Race	e - Americ	can Indian,
9	after or ite		1 ☐ Never Married 2 ☐ Married	Armed Force¶? 1 ☐ Yes 2 ☐ No If Yes, Give					erto Hica	an, etc.)			k, White,	etc.
93	ra",	d by	3 d Widowed 4 ☐ Divorced	Year or Dates:		1 □ Yes 2 <b>X</b>	140 3	pecify:				Specify.	Whit	:e
21215-0036	72 h	Completed	15. Decedent's Educ (Specify only highest grade	eation completed)	16a. Dece	edent's Usual O kind of work d DO NOT use re	ccupation	n na most of w	vorkina		16b. K	ind of Bu	siness/Ind	dustry
21	within iene. • than "	m pt	Elementary/Secondary (0-12)	College (1-4or 5+)			etired)							
2	filed w Hygie other ti				Home	e Maker	1.0					e Ma	-	
SU.	be fil ad ot ever	Be	17. Father's Name (First, Middle, Last)					. Mother's N			, Maiden	Surnam	e)	
3	should be and Mental is marked o	၉	Frank Johnson		T			Class		Duke				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar result be notified at		19a. Informant's Name/Relationship (Type  Mary Rainbolt (	Daughter)		ing Address (St Forest								
e, 1	1 and 2 Health Tem 27 i		20a. Method of Disposition					w DII	Date					own, State
ō	a		1 Burial 2 ☐ Cremation 3 ☐ R	emovar from State		osition (Name o matory or other						Juanon -	City or 10	WII, State
ţ	t. Pa tmer tant:		4 Donation 5 □Other (Specify)	Tri		Memoria				0,201			lorf,	MD.
Baltimore,	permit. Page Department Important: I any Injury o		21. Signature of Funeral Service Deense	9/		2. Name and A								00601
	40200		23a. Part 1. Enter the disease, or complia	2 mo119	-	035 O1d						ri,	MD.	Approximate
8760,	Physician /Medical Examiner  pnujaj-trausit	l Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecuence of the consecuence of t	quence of):								-6	Onset and Death
O. Box 6	or Attending Physician: The law requires that the death certificate be executed interdeath. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1	al death 3	□ Ectopic preg □ Other (speci						23d. Date of delivery Month Day Year		
rds, P.	quires that n signed b ıld be detz	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	underlying caus	e given ir	n Part I.						he cause of death?
8	w requir s been s should	lete	RENAL INS	UFFICIENT	7					24a. Was	an	24h. \	Were auto	opsy findings available
of Vital Records,	ician: The lav certificate has ector, page 2	Completed	CARDIOVASII	LIAR DISE						auto perfo 1 □Yes	ormed?		orior to co death?	mpletion of cause of 2 No
Κ	sician: certific rector,	Be	25. Was case referred to medical examiner?	ospital:			Other:	i. Place of E						
of	Physral di	유	1 Yes 2 No '' 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatie			4 Nursin		5/2 Res		•		ty)
on	ding F h. After funera	ion	1- Natural 5 ☐ Pending	(Month, Day, Year)	injury	M 200.	Injury at Work?	2 🗆 No	200	i. Describe	riow iriju	ry occur	eu	
isi	Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	29e Place of Injury - At h	ome farm et			2 🗆 140	201	Location	(Ctroot o	and Alexande	or or Pur	al Pauta Blumbar
Division	or A after Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)	reet, lactory, or	lice		201.	City or To			er or nur	al Route Number,
_	Hospital	Medical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kniner: On the basis of examin	owledge, dea ation and/or i	th occurred at to	the time, my opini	date and pl	ace, and	d due to the	e cause(s	s) and ma	anner as a	stated. o the cause(s)
	thin 2 the omple	Med	29b. Signature and title of certifier	and manner stated.		200 13	icense nu	ımher			204 0	ate eigne	d (Month	Day, Year)
	7 vitl		255. Organizate and time of certifier						/			-		
			, when			J.	7	1731	0		MA	KCH	05	2010
	BB4		30. Name and address of person who co	J PATEL	50	Print) POST	OF	TICE	RD	WA	4 LD	jef	MD	2010
	Sta Registr		31. Date filed (Month, Day, Year) NAR 0 8 201	32 Registrar's Sign	B. A.	tilled								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amended line 5/wchd/3-17-10/map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician 1409 2010 DORIS DORMAN /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fenmsula Dec was Medical Center Somboago Daging 3 6. Sex 7. Age (In yrs. last) der 1 Year | If Under 24 Hrs. Wicomico 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min. 213-30-9173 1 □ M 2 💢 F 19-1932 MD **Director** Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, The Medical Exercitive must be notified at 1 XYes 2 ☐ No Directo  $\mathcal{M}\mathcal{D}$ WICOMICO 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21875 9484 RUM RIDGE RD Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. "natural", or il important: If item 27 is marked other than "natural", or il any Injury or other traumatic event, the Medical Exaral any Injury or other traumatic event, the Medical Exaral any Dioce. 1 ☐ Yes 2 ☐ No Specify: ğ 3 ☐ Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jamesanna Wichels DORMAN ဂ္ဂ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUBERT FREEMAN (SON) 30248 MALLARD DR. DELMAR, MD 21875 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owantico, MD 21. Signature of Fyneral Service Licensee 23a. Part 1. Offer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MESSICK FUNEERI HOME POBOLGI BIVALUE, MD 21814 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Tue to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 No 9 I Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an has certificate tensio 2 No 25. Was c. e rred to medical 1 ☐ Yes 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 Anpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one)

law requires that the death certificate be executed P.O. Box 68760 Records, Hospital or Attending Physician: The of Vital Division 24 hours after deatl

filed within 72 hours after death with the Maryland

Baltimore,

To the within 2

State

30. Name and add ress of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Wieland 100 E Carrol STREET

29b. Signature and title of certifier

Registrar

29c. License number

D34768

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3 Day Year I O Reginald Sherman Massey BOY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death-HICOMICO AUS 6411 7. Age (In yrs. last birthday) 1 Year If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Ye 1 🖾 M 2 🗆 F Days Hours Min **Director** 219-36-6060 70 Virginia 1939 Nov. Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Delmar 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21875 107 Spruce Street within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 nent of Health and Mental Hygiene. ant; If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Construction Construction Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Hillman Samuel Sherman Massey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21875 Delmar, MD 107 Spruce Street Cecelia M. Massey (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Crematory of Delmarva03-10-2010 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 19940 13 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician choking asphysa che to disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months? Pregnant at time of death Year 2 No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page perform After this certificate I 1 Yes 2 No Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes မ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniun Natural 5 Pending 2 Accident 3/8/10 1 Tes 2 No 1730 M Choking on piece ot after death Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State Delnar, mo 24 hours a Home 107 Spruce St. Cyclifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurately the control of the cause Medical 29a. Certifier al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) To the within 2 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29ch Jens Olling > DME 059866

State Registrar md/Michael Murphy

npleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 24a, 25 per phys. & 29c per DVR 3729/10 dk

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death USA Physician/ Middleton Month Year UM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Genesis Plata Elder 41 Charles If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Marylane 1 🗆 M 2 🗹 F 92 Director 220-34-8388 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Benedict 1 Yes 2 No Manyland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18630 20612 USA should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian , or Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatin Elementary/Seconday (0-12) College (1-4 or 5+) Homensker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ nknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middleton Florine Page 1 and 2 20612 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other -13-10 4 Donation 5 Other (Specify) en 21. Signature of uneral Service Licenses Name and Address of Facilit 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be  $2\mathcal{H}_{\mathcal{A}}$  3S S Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown ייי שופים בחופים בחופים. Atter this certificate has been signed by י completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Deathy (Check only one) 2X No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 8 D21031 Wasldon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 old Line Center Site 3 31. Date filed (Month, Day, Year) MAR 10 32. State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Orbeck Ness Month Dav Year 9:534 03 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4 The lisbury Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Sex 1 ☐ M 2 ☐ F 9. Birthplace (State or Foreign 395-16-6127 Months Days Hours Min. OTTO 1921 **Director** North Dakota Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Salisbury 1 Yes 2 No Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 106 USA 1101 S. Schumaker Dr., 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates. AirForce 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Seconday (0-12) College (1-4 or 5+) Armed Services career military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helmer Ness Myrtle Johnson 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Nymber or Rural Royte Number City or Town, State, Zin Code) 1101 S. Schumaker Dr. 106, Salisbury, MD 21804 Augusta Ness/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any irjury or oth Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 3 10 10 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery Wilmington, DE Signature of Funeral 22 Hore Provey Spiritural Home P 501 Snow Hill Rd., Sali 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final ARIDMYD Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** HAONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes To the Hospital or Attending Physician: 'within 24 hours after death.'

To the Funeral Director: After this certifies 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 No Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 40SPICIZ 4 Nursing Home 5 Residence 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: injury 5 Pending 2 Accident 3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 1 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my policies. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 Vag. DO058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BU 31. Date filed (Month, MAR 10 egistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 3. Time of Death Physician/ John S. Noble 8:32 AM Medical 010 Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOS If Under 24 Hrs 8. Date of Birth (Month, Day, Ye Sept. 12, 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 🔀 M 2 🗆 F Months Yrs Country)
Delaware 222-10-7624 **Director** 1924 Usual Residence of Deceden 28a-f shov 10a, State 10b. County 10c. City, Town or Location death with the Maryland 10d, Inside City Limits Director notified 1 Yes 2 K No MD Wicomico Salisbury ö 10e. Street and Number 10f. Zip Code 23a c t be i 10g. Citizen of What Country? Funeral 27440 Waller Road 21801 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 □ No 194

If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o. þ 1 Never Married 2 X Married 1943 1 ☐ Yes 2 🕱 No Specify. "natural" 3 Widowed 4 Divorced Completed 1945 white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working ulth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 4 Mail Carrier Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be ment of Health and Menta John S. Noble Marian Hocker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau (Wife) Gertrude L. Noble 27440 Waller Road Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 03-12-2010 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens Hebron, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 13 East Grove Street Short Funeral Home Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ BSOPAAGRAL CARCINDANA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within E4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? Dav Year 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 Tes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other 1 Yes HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death
Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fifte of certifier 29d, Date signed (Month, Day, Year) DEOS 8410

Registrar
DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32, Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARCH SHIRLEY RUTH PEACH 33 PMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITAL FREDERICK FREDERICK MEMORIAL FREDERICK Social Security Number 216-50-9276 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Carrada 8. Date of Birth 1 24 15 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F 64 Days Hours Director Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Middletown 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7212 Limestone Lane 21769 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 No If Yes, Give Year or Dates. Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elemenary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last)
Rodney Rideout 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bert Peach (Husband) 7212 Limestone Lane, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation Smithsburg Crematory3/9/2010 Smithsburg, Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sign to of un rely ervice Lit Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. エルチャルペートン Immediate Cause (Final 3000009106 Physician/ disease or condition resulting in death) Medical Examiner Due to or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 2 🖸 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 1018939 who completed cause of death (tem 23a) (Type, Print) 7776-4 W 9 21769 31. Date filed (Month, Day, Year, 32. Registrar's Signature

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** inkne 2010 AM Whesley 2.5 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Marlhiro Gew Prince JOOM 9. Birthplace Country) If Under I year If Under 24 Hrs. Date of Birth (Month, Day, (State or Foreign Security Number 7. Age (In vrs. last birthday) Year) **Funeral** Ďays Min. Months Hours 1 🗖 M 2 🗆 F 216-22-030 5 32 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show 1 ☑Yes 2 ☐ No item 27 is marked other than "natural", or items 23a or 28a-f sl. other traumatic event, I'm Medical Examinar must be notified Director beorg Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with USA 20772 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince Georges permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. College (1-4or 5+) Elementary/Secondary (0-12) Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rel 20772 11410 200 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Voterans heltenham 4 Donation 5 Dother (Specify) enekun 21. Signature of Funeral Service Licensee 22. Name and Address 20608 M01589 14 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as nonsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed Exami burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No P.O. ed by the a 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. <u></u> 2☐No 3☐ Probably 4☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After t (Month, Day, Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 24 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

State

Line Center, Suite 30:

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Pace

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Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

Amend 24a per phys. 6902 4/15/10 dk

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Marc **Physician** Posey, Sr. Thomas Howard /Medical 4b. City, Town, or Location of Death If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | September 24, 1930 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland Months 1 ☑ M 2 □ F 79 220-16-4632 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items the multiled at once. 1 ☐ Yes 2 ☐ No Director Charles La Plata MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20646 USA 6225 Cool Springs Farm Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married White 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Land Developer Home Builder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Randolph Hyde Francis Wills Posey, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6225 Cool Springs Farm, La Plata, MD Verna Posey/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition n Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Ignatius Cemetery 3/6/2010 Port Tobacco,MD 21. Signature of Funeral Service Licensee ²²AREHARTECHOUS FUNERAL HOME, P.A. M00945 Echo 211 St. Mary's Ave. La Plata, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1sttuc Cunter Metash **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No e has been signed by the ge 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown Muctive Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an (sranga autopsy perform this certificate had director, page 2 🗆 No 2**₹**No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 XNo 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After t 1 Natural 2 Accident 5 ☐ Pending investigation n 24 hours after death.

ne Funeral Director: Aft
pletely filled in by the fun 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 \( \triangle \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \( \triangle \) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. Medical 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print) PO BOX 2665 La Plata, MD 20646 Jenkink La Grange 32 Registrar's Signature 31. Date filed (Month, Day, Year)
MAR 0 8 2010 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2010 Year **Physician** March 10. 0055 Frank Robinson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Havre de Grace Harford Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Jan. 20, 1 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Ĩ′926 111-14-9627 84 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be reaffied at once. 10a State 10c. City, Town or Location 1 ☐ Yes 2XXNo Director Conow ingo Cecil Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21918 38 Cinnamon Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: WW II 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry Frank Robinson & ASSOCIATES 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, po NOT use retired)

Manufacturer's Representative Owner/Operator College (1-4or 5+)
Two Years Elementary/Secondary (0-12) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Allen Joshua Robinson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Cinnamon Drive, Conowingo. Maryland 21918 19a. Informant's Name/Relationship (Type. Print) (wife) Wanda T. Robinson Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ellicott City, 03/16/10 Good Shepherd Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Maryland Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licenset 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner THROMBO CYTO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-trar Due to (or as a consequence of) Physician/Medical the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?

1 Yes 2 No 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? performed! 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To this 27. Manner of Seath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 🗷 No n 24 hours after death.

e Funeral Director: A letely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier npletely 1 (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S UNION AVE HAVRE DE GRACEMO 21078 PUTHAWALA MD KHALID 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Conve

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 19, 2010 4:45 p M Rachel Brown Roesser March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Elkton Elkton Care and Rehab If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 28 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1927 Min Months Days Hours 1 M 2 XF Virginia Nov 194-20-9903 82 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show Earleville 1 ☐ Yes 2 No Funeral Director Cecil MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. U.S.A. 30 Cecil Rd. 21919 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐Yes ≱☐No Specify. If Yes, Give Year or Dates: Specify: \$ 3 X Widowed 4 □ Divorced Completed er than "natur. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ith and Mental Hygiene.

27 is marked other than 'r traumatic event, the Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Ragland Ernest Thomas Washington Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Ronald N. Brown (nephew) 1106 Piper Rd. Wilmington, DE. 19803 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 3/24/10 Kent Cremation Smyrna, DE. 5 ☐ Other (Specify) 4 Donation 21. Sign for of Fun at Service Licens Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 M00510 Fert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Talle to thrum disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Deventa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4 Pregnant at time of death Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Dep Temon Hyperterg on 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy DM 1 ☐Yes 2 XNo typest within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 V Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

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Physician

Cover ine

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dress of person who completed cause of death (Item 23a) (Type, Print)

na 38. Registrar's Signature

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Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 4, Day 2010 **Physician** Year 1825 Ruth Smith Jeannette /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WORCESTER SNOW HILL HARRISON SENIOR LIVING If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day Year) 06 03 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2 F Months Days Hours Maryland 92 214-80-7836 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits •how r 28a-f ehov 1 No 2 No Director Maryland Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "naturel", or Iteme 23a or the Medical Examinar must be 430 W. Market St. 21863 USA Funerai filed within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic wermit. Peges 1 end 2 should be filed. Department of Heelih and Mental Hillem 27 is meriany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rose Leight Lester S. Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Fosse Grange, Ocean Pines, MD 21811 Richard E. Smith/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Salisbury Crematory | 3 8 10 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 227Nan and Addess of Funeral Home, Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 arra DOMPSON 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bronar **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclen and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 **X**No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause ol death? 24a. Was an page 2 s autopsy performed? 2□ No 1 Yes 22 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No I Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March. -04-2016 3 m 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Market

1604

Registrar

State

32. Registrar's Signature

BARAL; MD

31. Date liled (Month

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 STEWAR Physician/ EliSE Eborah 2010 3:47 AM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Hospice At the Lake Salisburg Wicomico 9. Birthplace (State or Foreign Country) MARY AND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 - 4 - 59 7. Age (In yrs. last birthday) 6. Sex Funeral Hours 1 □ M 2 🖾 F 50 **Director** Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 72 hours after death with the Maryland the Medical Examiner must be notified at Director MARYLAND Wicomico Salisburg 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 Funeral items 23a KOAd Morris 459 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: Black If Yes, Give 3 🗌 Widowed 4 🗎 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NONE DomEstic 12 injury or other traumatic event, Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Himportant: If item 27 is more. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ STEWAR CLINTON MARY AllEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mill Road MARY A. STEWAR SAL (Mother 11) DRRis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4-19-2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens e Will SAlis. Home 821 WEST FUNERAL ROAD TEWAR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Carcinoma a Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗷 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 1 🔀 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 🛮 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The desiration of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 03-14-2010

DHMH 17 Rev 7/2009

State Registrar Regist ar's Signature

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR.; SALISBURY, MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-01066 Nicole Tull

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day February 6, 2010 Nicole **Medical Examiner** 0303 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Hospital Center Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs, last birthday) Foreign Months Hours Director UNKNOWN 1 M 2 X F Country) WARY/ANG Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No SALISDURY nours after death with the Maryland 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21804 USA PEE 238 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married Yes Black If Yes, Give Year or Dates: 4 Divorced 1 Yes 2 No specify: Specify: "natural" 호 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 lent of Health and Mental Hygiene.

Int: If item 27 is marked other than "I nother traumatic event, the Medical E Baltimore, MD 21215-0036 DOMESTIC 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) EVERE ARIENE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2,061 19a. Informant's Name/Relationship (Type, Print) Orchard Ka Aō MoTh 065 GREEN (9) EN KLENIE ENE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State SHIE DURY (REMA ORY Donation 5 Other Specify neral Service Lice 22. Na e and Address of Fa ility 23g Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Acute Bacterial Bronchopneumonia with Pleuritis Examiner or condition resulting in death) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence or): events resulting in death) Last Physician/Medical X UNPENDED AMENDED 23a,27 per me g901 3-25-10 vt The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes Fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 Other4 this ( ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes 28a Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending Investigation 1 Yes 2 No Director: within 24 hours after death.

To the Funeral Director: Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 7, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006** 

State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>010</u> Physician/ Month Vidas Silvia Maria 10:30A March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 340 East Magnolia Washington Hagerstown 5. Social Security Number 8. Date of Birth (Month, Day, Jan. 28 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Days 1 🗆 M 2 💢 F Hours Country) Director 220-28-2801 933 Maryland Usual Residence of Decedent ms 23a or 28a-f shov must be notified at filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland | Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a 340 East Magnolia 21742 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 No Completed by Maryland 21215-0036 1 Tes 2 No Specify 3 Widowed 4 Divorced White Year or Dates. the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Cashier Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Is marked of ဂ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Vidas Miller Minnie M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vince U. Vidas / Brother 340 East Magnolia Hagerstown Maryland 21742 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 3/18/2010 Smithsburg, Maryland 21. Signal of Funera Service Lica see 22. Name and Address of Facility Rest Haven Funeral Chapel ι 1601 Pennsylvania Ave. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Year Pregnant at time of death 1 Yes 2 the 9 Unknown P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law has autopsy performed?
1 ☐ Yes 2 🔀 No death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? in 24 hours after death.
in 24 hours after death.
the Funeral Director. After this ce 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

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State Registrar 3

Μ. 31. Date filed (Month, Day NAR 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2010 Register's Signature

Waseem,

29b. Signature and title of certifier

Khalid

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1126 Opal Court Hagerstown, MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 9:45₺ Mary Margaret Wootten March 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Cecil Union Hospital E1kton If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jun. 27, 19 Birthplace (State or Foreign Country) Months 1 □ M 2√□ F 66 221-28-4692 1943 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1√ Yes 2 No Cecil North East 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21901 USA 111 E. Cecil Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry  $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Line Worker Aluminum Fabrication 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Milton Swann Margaret Moran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4021 Rosetree Ln. Newark, DE 19702 Kathleen Martin/ daughter 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/11/2010 R.T. Foard Funeral Home, P.A. Rising Sun, MD 22. Name and Address of Facility 21. Signar re of Funeral Service icensee Foard and Gee E. Main St. Elkton, MD 21921 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) xanguinat Due to (or a a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Co Due to (or as a consequence of): yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Wior 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Physician /Medical **Examiner** Examine

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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**Funeral** 

Director

show

ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite any Injury or other traumatic event, Ite Medical Examina

Baltimore, Maryland 21215-0036

JD

death with the Maryland

law requires that the death certificate be executed and burial-trar Box 68760, attending physician for use signed by the a P.0. Division of Vital Records,

has

After

Hospital or Attending Physician:

death. after death Director:

within 24 hours a

10

Physician/Medical completely filled in by the funeral director,

<u>6</u>

Completed

Be

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Certification:

Medical

9 Unknown

2 1 No 1 Tes 27. Manner of Death

1 Natural

2 Accident

29a. Certifier

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State o	of Mary		Department o Certificate o				giene Reg. No.	2010	09107
	Physicia	in/	1. Decedent's Name (First, Min Shirley	Bromley	TATO	est				Date of Dea     Month	ath Dav	Year	3. Time of Death
Angle.	Medic	cal	4a. Facility Name (if not institu				4b. City, Tow	n, or Locati	on of Death	03		County of Death	8:17A M
1	) 		Coastal lb:	spice, at		Lake	Sau's		der 24 Hrs.	0.0.1.10	_	comic	
	Funeral Director		214-30-8707	1 M 2 F	7. Age (In	yrs. last birth		ays Hou		8. Date of Birt Month, Day 03 10		9. Birth Cou <b>Ma</b>	nplace (State or Foreign ntry) ryland
	at at	٥٠	Usual Residence of Decedent 10a. State 10b. Cou		10	c. City, Town	or Location						10d. Inside City Limits
	Maryla 28a-f	irect	-	rcester			Snow Hill	l					1 🗌 Yes 2 💆 No
	s 23a or	Funeral Director	10e. Street and Number 6887 Snow Hil	ll Road			10f. Zip Co 218				10g. Citiz	zen of What Cou SA	intry?
9800	should ce filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status  1  Never Married 2  1  3  Widowed 4  Divor		rces? 2 X No	in U.S.	13. Was Decedent If Yes, specify (			cify Yes or No- Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh	
ん. いとさ Maryland 21215-0036	vithin 72 hou liene. Ir than "nat the Medica	Completed		edent's Education ighest grade completed)  2) College (1		<b></b> ∫ :	Decedent's Usual Oc (Give kind of work do life. DO NOT use reti 11de	one during n	nost of worki	ng		nd of Business Ir	ndustry Nucation
yland 212	ld e filed w Mental Hyg arked othe	To Be	17. Father's Name (First, Midd. Alvin Davis	le, Last)				18. M	other's Name Nellie	e (First, Middle, 1)	Maiden Si et	urname)	
-37	~ = 5- 5		19a. Informant's Name/Relation Irene Simpson		.,		Mailing Address (Str 209 Belgr	cave C	mber or Rura	Route Number alisbury	r, City or T Y , MD	own, State, Zip 21801	Code)
Saltimore,	Page 1 ant of Fant of Fant: If ite		20a. Method of Disposition 1		State	cemeter)	Disposition (Name o , crematory or other ns Cemeter	place)	3 10	Date 10		eation - City or T Sbury,	
Batt	per it. Page 1 and 2 Derartment of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Servi	Ligenspe	CA	33	-		-				sociation
J	Physician, ) Medical	8 6	23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	ist only one cause on a	Stac	death. Do no	onie Ots			r respiratory arr		ease	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Uue to	or as a co	nsequence of	):						,
0	sate be executed physician and the burial-transit	edical Exan	Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):										
Division of Vital Records, P.O. Box 68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Birth 2 C		3 Ectopic preg				2:	3d. Date of delive Month	very Day Year
ls, P.O.	uires that th signed by lid be detac	by	Part II. Other significant cond	ditions contributing to de	eath but n	ot resulting in	the underlying caus	e given in P	art I.				he cause of death?
$\ddot{\circ}$	law las	Completed								24a. Was a autop perfor	rmed?	24b. Were auto prior to co death? 1 \(\sum \) Yes	ppsy findings available ompletion of cause of
ital	ician: certifica	Be	25. Was case referred to medic examiner?	Hospital:			-1	Other:	Death (Check	only one)			17
of V	ding Physician: The thr. The thr. After this certificate funeral director, pag	e: To	1 Yes 2 No 27. Manner of Death	28a. Date	of injury	28b. Ti	me of 28c.	niurv at		me 5 Resid		Other (Specification)	105pice
ion	tendin death. tor Aff the fur	Certificate:		estigation	th, Day, Ye		M	vork? I ☐ Yes 2					
Divis	To the Hospital or Attending Physician: The within 24 hours feer death.  To the Funeral Director After this certificate I completed filled in by the funeral director, page		4  Homicide dete	ermined 28e. Place buildir	ng, etc. (S _i	pecify)	n, street, factory, off			City or Town	n, State)		l Route Number,
	he Hosp iin 24 hos he Fune ipleted fi	Medical	(Check 2 Medic	ring Physician: To the be al Examiner: On the bas ring Nurse Practioner:	is of exami	ination and/or	investigation, in my o	pinion, death	n occurred at	the time, date ar	nd place, a	and due to the ca	use(s) and manner stated.
	To t		29b. Signature and title of cert	M. Bel	los	7 m		ense numbe		2		signed (Month,	Day, Year) 2010
	YIM	1	SO. Name and Address of pers GREGORIO					36.RR\	DR.	SALISI	B1112°	Y MD	21801
	Stat	e	31. Date filed (Month, Day, Yea,		egistrar's S		bares			-11-121	J 641	11.12	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Day Sereta Ballard White /Medical 3 2010 6:30 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manokin Manor Princess Anne Somerset 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 □ F Hours Yrs Director 130-18-2940 10-9-1913 MD Usual Residence of Decedent 10c. City Town or Location ed other than "natural", or items 23a or 28a-f show event, the Madeal Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Princess Anne Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11974 Edgehill Terrace 21853 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Yes Give 3 ☑ Widowed 4 ☐ Divorced Specify: Black "natural", Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mades once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Baby Sitter Child Care Service Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) George Ballard 2 Rebecca Bell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ted Phoebus/POA 31030 Cooper Lane, Princess Anne, MD 21853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bowland Hill 3/13/2010 Princess Anne, MD 4 ☐ Donation 5 ☐ Other (Specify) John Wesley Cem 22. Name and Address of Facility 917 W. Isabella St ture of Funeral Service Licensee Bennie Smith 917 W. Isabella St Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Find disease or condition resulting in death) Physician 10 years /Medical Due to (or as a consequence of): Examiner DENENDA 1546ans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been si e 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha rector, page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) the within 2.

State Registrar

1415 6. DIVISION ST, SALISBURY NATESAN. DR. USHA 31. Date filed (Month, Day, Year) MAR 10 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

WH Now

32. Pegistrar's Signature

29c. License number

0051354

29d. Date signed (Month, Day, Year)

March 8/5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				2016 lealth and Me of Death	lental Hygie	/ 11 1 1 1	09109
Pi	nysicia	n/	1. Decedent's Name (First, Middle, Last) Annie Mae Washington		2. Date of Death	Day8 , 20°1"0	3. Time of Death 8:59p • M
-	Medic Examin		4a. Facility Name (if not institution, give street and number)  4b. City,	Town, or Location of Death		4c. County of Death Prince	
	uneral rector		5. Social Security Number 6. Sex 1 $\square$ M 2 $\square$ F 7. Age (In yrs. last birthday) 86 Yrs.	Days Hours Min.	8. Date of Birth (Month, Day, Ye Dec 30	9. Birth Coun	pplace (State or Foreign
laryland	3a-f show tified at	ector	Usual Residence of Decedent         10b. County         10c. City, Town or Location           MD         Prince Georges         Brandywine				10d. Inside City Limits 1   1 Yes 2 □ No
with the M	s 23a or 28 ust be not	Funeral Director	10e. Street and Number 15600 Croom Road 206		¹⁰⁹ US	. Citizen of What Cou A	ntry?
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	ıral", or item Examiner m	þ	Armed Forces? If Yes, spec	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F 2 ^X No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, SpecifyBlac	etc.
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.	er than "natu the Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)  College (1-4 or 5+) College (1-4 or 5+)	rk done during most of workir e retired)	ng	o. Kind of Business Ir	ndustry
/land	irked oth	To Be	17. Father's Name (First, Middle, Last) Alexander Schools	18. Mother's Name			
, Man, od 2 should saith and N	n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print)  Floyd Washington, Son  19b. Mailing Address 15600 Cr	s (Street and Number or Rural	Route Number, Cit Brandywi	y or Town, State, Zip .ne, MD	^{Code)} 20613
timore Page 1 ar ment of He	tant: If iten jury or oth		20a. Method of Disposition  1	other place)	ZUJU L.	chmond,	
Ball permit Depart	any in		21. Signature of Juneral Service Consult Walter Walter	nd Address of Facility Pr J. Mannir N 25th Stree	ng Funer	al Home	23223
Exa	ician/ edical miner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or a a consequence of):  Aspiration Pneumon death and sequence of the conditions, it any, leading to immediate cause. Enter Underlying	phalopathy	respiratory arrest,		Approximate Interval Between Onset and Death
'60 ate be execute	onysician and the burial-tran	dical	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.				
P.O. Box 68760 that the death certificate be executed	i been signed by the attending physician and should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic; 4 Pregnant at time of death 5 Other (sp.			23d. Date of deliv Month	ery Day Year
IS, P.O	n signed by	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause given in Part I.		co use contribute to t	he cause of death?
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.	r, page 2 shor	Completed by	W *		24a. Was an autopsy performed	prior to co death?	psy findings available impletion of cause of
Vital	directo	To Be	25. Was case referred to medical examiner?  1	26. Place of Death (Check Other: 4 \( \subseteq \text{Nursing Hon} \)		e 6 🗆 Other (Specify	·/)
on of ending Pt eath.	or: After tr he funeral	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ AccidentInvestigation M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	8d. Describe how in	njury occurred	-
DIVISI	ral Direct		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)		City or Town, St		
the Hosp	the Fune	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death occured at 2 Medical Examiner: On the basis of examination and/or investigation, in a only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occur	my opinion, death occurred at rred at the time, date and place	the time, date and ple, and due to the cau	ace, and due to the ca se(s) and manner as s	use(s) and manner stated. tated.
5 with	28		29b. Structure and title of partifier 29c	0.19633 019633	29d.	Date signed (Month,	Day, Year)
	)		30. Name and address of person who completed cause of death (Item 23a/(Type, Print)	sRd#201	AClint	on Wel	20735
R	Stat egistra	_	31. Date filed (Month, Day, Year)  MAR 0 4 2010  Line S. Gardel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 5. [□]2010 Year 12:40 AM **Physician** William Zimmerman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Futurecare Pineview If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min. Months Days Hours 1925 Virginia 212 20 9067 84 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must by notified at 1 ☐ Yes 2√No Prince George's Clinton Director Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20735 5705 Alan Drive death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No WWII If Yes, Give Year or Dates: 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√√XNo Specify Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7th and Mental Hygiene. College (1-4or 5+) Construction Roofer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon Dickson (Daughter) 5705 Alan Drive, Clinton, MD Health a permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tn
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 3-24-2010 Cheltenham, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, 21. Signature of Funeral Service Ligensee Inc. Tionis & Frank 20735 Alexandria Ferry Road, Clinton, MD m00257 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardio Viscular Atheroscleratic Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical 23d. Date of delivery 23c, if yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Obstructive 2 in sea so Luno 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl autopsy performed' 2 XNo 2 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. After t ours after death.

leral Director: A
filled in by the fu within 24 hours a

To the Funeral L

Certification: To

Medical

5 ☐ Pending investigation 2 Accident 6 □ Could not be

3 Suicide 4 🗌 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day) Year) 2010

29a. Certifier

(Check only one)

0 B) ( 5 3/

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0050545

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Okoji, MD 1809 Benning Rd. NE Washington, DC 20002 Godswill

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item | per doc g902 4-8-10 vt |
State of Maryland / Department of Health and Mental Hygiene 1 - State Amend #5, per FH g902 4/15/10 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ [™]O3/23/201€ 10:00AM M Delores Ethel Allen Dolores Allen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hillhaven Nursing Center Adelphi Prince George's 5. Social Security Number 578-22-2773 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕱 F Hours Min. (Month, Day 02/12/ Washington, DC Director 87 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD 1 K Yes 2 No Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1312 Elson Place 20912 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 ☐ Yes 2 🛛 No Specify: White "natural", 3 Widowed 4 Divorced Specify: Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Morganston Ethel May Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Morgan Allen / Son 1515 Buckeystown Pike, Adamstown, MD 21710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 03/24/2010 Hanover, Maryland 21. Signature of uneral Septice licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consumuence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Use to for sels noneequence of Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 🛱 No the been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 Ne 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy performed? death After this certificate Yes 2 No 2 1 No filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Latural 5 Pending 1 Yes 2 No Investigation Could not be Accident 2 Accident
3 Suicide
4 Homicide within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who pleted cause of death (tem 23a) (Type 31. Date filed (Month, Day, 32. Registrar's State Registrar

State 31. Date filed (Month, Day Year)
Registrar AAR 2 5 2010

DHMH 17 Rev 1/2001

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32. Registrar's pignature

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAR 2090 en Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2613 Royal Baltimore Co. Oak Ave woodlawn 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Carolina 1 🗆 M 2 🖾 F Days Months Hours Min. 12/30/ Director 218-42-8867 66 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 10d, Inside City Limits 28a-f 1 Yes 2X No MD Baltimore Co. Woodlawn 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? injury or other traumatic event, the Medical Examiner must be Completed by Funeral 23a 2613 Royal Oak Ave. 21207 U.S.A. items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married P Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Nursing Asst Private Duty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Vernie Peoples Annie Dell Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Eva Lane(Daughter) 1802 Ν. Spring St., Baltimore, MD 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. 02/09/10 Zion Cem. Baltimore, MD 21. Si nature of Funeral Service Licensee Josephadrs of Brown Jr. Funeral Home any 2140 N. Fulton Ave., Baltimore, MD 21217 art 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or neart failure. List only one cause on each line Approximate val Between set and Death mediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Directs (or as a nonsequence of Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last the Hospital or Attending Physician; Tie law equires that the death certificate be attending physical for use as the b Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown Ves 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; t 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 No Other 1 Tyes 은 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) License numbe 29d. Date signed (Month. Dav. Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Contificate of Death

		-	For State Registrar	State of Maryland		irtment of H <i>tificate of D</i>			giene Reg. No. 2 (	10	09114
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ith		3. Time of Death
	Physicia Medic		Joyce A. Ar	tis				Month March	18, 2	Year 2010	19:00p ^M
	Examin		4a. Facility Name (if not institution, give stre	eet and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
			Southern Maryland			Clinton If Under 1 Year	If Under 24 Hrs.	0 Date - ( Dist			orge's
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las	Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day	(Year)	9. Birtiipi Counti VA	ace (State or Foreign ry)
			231-64-3176 Usual Residence of Decedent	1 61				7-23-19	1481	V F	7
	and shov	ē	10a. State 10b. County	10c. City,	Town or Loc	ation				10	0d. Inside City Limits
	Maryl 28a-f otifie	rec	MD Prince Ge	orge's Ft.	Washi	ington					1 🏋 Yes 2 □ No
	aor;	a D	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Count	try?
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	1800 Palmer Rd Un		- 1	20744			USA		
	r iten iner i		11. Marital Status  1X Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	city Yes or No- Rican, etc.)		e - America ck, White, e	
2-003p	filed within 72 hours after death with the Maryland the Hygiene. Hygiene. A thygiene and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 No	Specify:		Specify.	B1a	ick
5	hours natur lical I	Completed	15. Decedent's Educ	ation	16a. Deced	ent's Usual Occupa	ation		16b. Kind of B	usiness Ind	ustry
2	in 72 e. nan "r	틹	(Specify only highest grade Elementary/Seconday (0-12)	College (1-4 or 5+)	(Give k life. DC	ind of work done do NOT use retired)	uring most of worki	ng			
	within ygiene. ner thai t, the N		12th		Supe	ervisor			US Post		rvice
<u>n</u>	e filed ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			<del>e</del> )	
Maryland	buld be fi d Mental marked matic ev		Herbert Randolph A				Lillian			24-4- 7:- 0	- da)
¤ Z	2 should Ith and Ma 27 is mar r traumati	H	19a. Informant's Name/Relationship (Type,			g Address (Street a					
	1 and 2 should be f Health and Men item 27 is marke other traumatic		Sebrina Artis Mille 20a. Method of Disposition	20b. Pla	ace of Dispo	Sly Fox sition (Name of		Date Marin	20c. Location		nd 20772 wn, State
Ē	- 0		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	inoval irom State		natory or other place oln Cemet	i	: /2010	Brontin	od N	faryland
altımore,	11 F F F		21. Signature of Superal Service Licensee	4	7 22	. Name and Addres	s of FacilityMars	shalls F	Funeral	Home	of Marylan
ñ	permit Depar Impor any in	li	Victoria, 1	. Woods		308 Suit1			l. Maryl		20746
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	ations that caused the death cause on sach line.	. Do not ente	h					Approximate Interval Between
-	nysician/		Immediate Cause (Final disease or condition	alhansel	erale	Clerce	20 VASC	ulas 1.	I Scal	e-1	Onser and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque		~ !	1 0	10	f dans	. /	1: -
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	9/55/2 ence of):	neres/ c	e 10	900	J. R. CO Z.		h /monor
0	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Sarge	61-	7				0	In Known
D.	executed an and rial-transi	Ĕ	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):	007	7			,,	
09	sate be executed physician and the burial-transit	edical		1) IABSelv	Me	llile	7			12	Moun
289	certifica anding pl use as tl	/We	IF FEMALE:	c. If yes, outcome of pregnan	201/						
Box	ath ce	jan	in the past 12 months?	1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnanc Other (specify)	у			ate of delive onth	Pry Day Year
ă.	ne death or the atter	Physician/M	1 Yes 2 VNo 9 Unknown	9 Unknown	eatii 5 _	Other (apoony)					
O.	law requires that the death certific nas been signed by the attending p a 2 should be detached for use as		Part II. Other significant conditions conti	ributing to death but not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use cont	ribute to th	e cause of death?
S,	uires n sign	ed t	Dapression			***		1 🗆 '	Yes 2 ☐ No	3 Prob	pably 4 Unknown
Records,	w require la pee	Completed by						24a. Was		Were autop	osy findings available mpletion of cause of
Ř	The la	E O						perfo	rmed?	death?	
Vita	sician: The law of certificate has be irector, page 2 s	Be (	25. Was case referred to medical examiner?	spital:			ace of Death (Chec	k only one)			- 1
Ē	Physic this o al dire	은	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ I	ER/Outpatier 28b. Time of		4 ☐ Nursing Ho		dence 6 Oth		
0	d <b>ing F</b> h. After funer	ate	1 ☑ Natural 5 ☐ Pendi <i>n</i> g	(Month, Day, Year)	injury	work	? Yes 2 \sum No	28d. Describe n	ow injury occur	ea	
Sio	Atten	Certificate:	2  Accident Investigation 3  Suicide 6 Could not be 4  Homicide determined	28e. Place of Injury - At hor		eet, factory, office			Street and Numb	er or Rural	Route Number,
Division of	tal or s afte al Dire			building, etc. (Specify)				City or Tow	/n, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Stamine)	ian: To the best of my knowler: On the basis of examination	and/or invest	rigation, in my opinio	n. death occurred a	t the time, date a	ınd place, and du	ie to the cau	ise(s) and manner stated.
	thin 2 the l	×	only one) 3 Certifying Nurse I	Practioner: To the best of my	knowledge, o	death occurred at the		ce, and due to th	e cause(s) and m 29d. Date signe		
	¥ ≥ ¥ 8		<b>)</b>	That		500	154	l di	March	,19	2010
			30. Name and address of person who on	pleted cause of death (Item	23a) <u>(Typ</u> e, F	Print)	01				
	15		9135 PISCATO	was Rd.	Sul	235	clista	OWN	2073	2	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure Land						
	เเษยูเอแ	œU.	WAD 9 5 2010	I WILLIAM SIL	Agree .						

DHMH 17 Rev 7/2009

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

items 23a or iner must be n

r than "natural", or iten the Medical Examiner filed within 72 hours after Hygiene.

7 is marked other traumatic event, tl

Department of Health Important: If item 27 any injury or other to once.

s 1 and 2 should be fill Health and Mental H tem 27 is marked oth

Pages 1

Director

Funeral

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Completed

death with the Maryland

Maryland 21215-0036

Baltimore,

be executed physician and strans Box 68760. as attending properties for use as P.0. ģ signed t Records,

Division or Vital

Hospital or Attending

Examine Physician/Medical þ Completed page 2 s cate h Be P this funeral Certification: After death. 24 hours after death e Funeral Director: the filled in by

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2 No 9 Unknow

29a. Certifier

(Check only

29b. Signature and title of geriffier

Hospital: 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be 4 Homicide

MAR 25 2010

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 3/18/2010 47867

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4701 Randolph Road & 216, Rockville, MD Zuniga, MD

and manner stated.

31. Date filed (Month, Day, State Registrar

Medical

the within 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 2010 11:45 AM Zack Burtt March Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 2, 1940 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Country) West Virginia 1 3 M 2 - F Director 69 232-62-7678 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No WV Berkeley Hedgesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 371 Ben Speck Road 25427 USA should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 X Yes If Yes, Give Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Divorced 4 Divorced Year or Dates. Unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Brake Cable d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Margaret M. Saville Lyman C. Burtt and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trae 25427 371 Ben Speck Road, Hedgesville, WV Doris Lou Burtt/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Pleasant View Memory Gardens 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mar.22,2010 Martinsburg, WV . Signature of Funeral Service License Brown Funeral Home 22. Name and Address of Facility 327 W. King St., Martinsburg, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Intestinal Ischemia Medical Due to (or as a consequence of): Examiner Atherosclerotic Coronary Artery Disease Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
Peneral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 2 No Yes 2 X N 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hospital: 10 1 🗌 Yes 2 XNc 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? iniury 1 XNatural 5 Pending 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Within 2 To the F only one 29b. Signatu 29d. Date signed (Month, Day, Year,

State Registrar KATHLGEN

31. Date filed (Month, Day, Year)

7910 CALLOLL AVE

SUITE 440

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26, 27 perPHYS, G901, 37257 2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:21P Medical <u>March</u> 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clem and Doll Assisted Living Randallstown Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F (Month, Day, Year) 5-11-1915 Country) Director 213-28-1595 Yrs. 04 MD Usual Residence of Decedent or 28a-f show of Health and Mental Hygiene. i tem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🌠 No Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bailey Funeral with 716 Templecliff Road 21208 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 21215-0036 1 ☐ Yes 2 X No Specify: African-American Completed 3 Widowed 4 Divorced Selma Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Hochschild Kohn Be Maryland filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ þe Willie Boyd HattieHatchet je 1 and 2 should b t of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Bailey/Grandson 716 Templecliff Road, Pikesville, MD 21208 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memoriai Park 3-20-2010 Arbutus, MD 21. Sign ture of Funeral Service License Wylie Funeral Home P.A. of Balto. Co. 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Alzheimer Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a echecquenes or). been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed eight that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Preumonio Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed Yes 2 1 Tes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted Living Hospital: 1 Tyes 2 X10 Other: 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. sing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No X Natural injury 5 Pending ☐ Accident
☐ Suicide
☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 40048 Mar 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . Registrar's Signa State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of Ma	•	•	ent of Healt ate of Deati		Mental Hy	giene Reg. No.	2010	1 1911	5
	Physicia	n/	1. Decedent's Name (First, Middle, Las		NINGH	t An	1		2. Date of De Month MAR	eath Day	2°1 c	3. Time of Death 9:45 P	M
	Medic Examin	er	RONALD: 4a. Facility Name (if not institution, give University of Merry)	street and number)	1 Cente	4b. Ci	ty, Town, or Location	on of Death		4c.	County of Death	1	
Ī	Funeral Director		5. Social Security Number 6. \$ 219-62-1421	ex 7. Age	(In yrs. last birthda 54 Yrs	(ay) If Und Month	der 1 Year If Und	der 24 Hrs. s Min.	8. Date of Bir (Month, Da 04/28/			nplace (State or Foreig entry) MD	חן
	and show	ř	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limit	s
	Maryl. 28a-f otified	irect	MD		Balti							1 🛣 Yes 2 🗆 N	10
	ith the 3a or t be n	ral D	10e. Street and Number	L			Zip Code 1230			-	izen of What Coi JSA	untry?	
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	<b>Funeral Director</b>	1231 Cross Stree	12. Was Decedent Ev Armed Forces?		13. Was Dec	edent of Hispanic ecify Cuban, Mexi	Origin? (Spican, Puerto	pecify Yes or No- o Rican, etc.)		14. Race - Amer Black, White		
036	s after ral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🙀 Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates.	lo	1 🗆 Yes	2 No Spec	cify:			0 15	ite	
15-0	72 hour n "natu ledical	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(G		sual Occupation work done during m	nost of wor	king	16b. Ki	nd of Business I	ndustry	
212	within /giene. ner tha t, the N		Elementary/Seconday (0-12)	College (1-4 or 5+	)	sable	,						
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)  Thomas Birmingha	ım					ne (First, Middle, 'ilbur	Maiden S	Sumame)		
ary	should and Me is mar raumati		19a. Informant's Name/Relationship (To		19b. M	lailing Addre	ess (Street and Nur			er, City or	Town, State, Zip	Code)	
φ, Σ	and 2 s Health em 27 ther tra		Sherry Birmingham	n/Daughter			hington	Blvd.					
more	Page 1 anent of Hant of Hant: If ite		20a. Method of Disposition  1 ☐ Burial 2 🙀 Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif	Removal from State	20b. Place of Di cemetery, of Arrient C	crematory of	ame of rotherplace) on Services	03/	Date 22/2010		cation - City or		
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Hea Important: If item any injury or othe		21. Signature of Funeral Service Licens		TEGGIO G	22. Name	and Address of Fa	cility Ar	dent Cr	emat:	ion Serv		
r			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only o	olications that caused t ne cause on each line.	he death. Do not			-			Lario Vol.	Approximate Interval Between	_
garden	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	consequence of):	alh	utritio	n				Onset and Death	
	Examiner	<u>.</u>	Sequentially list conditions,	b. ————									
	ted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence of):								
Ø	cate be executed physician and s the burial-transit	al Ex	that initiated events resulting in death) Last	Due to (or as a	consequence of):								
2092		ledical		d									_
Division of Vital Records, P.O. Box 68	th certif ttending or use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death					2	23d. Date of deli Month	very Day Year	
). Bo	the dea by the a ached f	hysic	1  Yes 2 No 9 Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	time of death	5 U Other	(specity)						
s, P.C	res that the death certifica signed by the attending p d be detached for use as	by	Part II. Other significant conditions of	ontributing to death but	t not resulting in th	ne underlyin	g cause given in P	art I.				the cause of death?	vn
ord	w require s been sig s should b	Completed							24a. Was		24b. Were aut	opsy findings available ompletion of cause of	Э
Rec	The la cate ha									2 No	death?	2 🗆 No	
/ital	sician: certifi	m	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	nt 2 🗆 ER/Outpa	utiont 2 🗆	26. Place of D			J 6	Other (Case)	6.A	_
of V	ng Phy fter this ineral d	ste: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	28b. Time	e of	28c. Injury at work?	Nursing H	28d. Describe I		Other (Special occurred	<u>y</u>	
sion	Attendia death. ctor: A	Certificate;	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b		y - At home, farm,	M street, factor	1 Yes 2	! □ No	28f. Location (	Street and	l Number or Rura	al Route Number,	_
DIV	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as			building, etc.	(Specify)				City or Tov	vn, State)			_
	e Hosp 24 hor e Fune pleted fi	Medical	(Check 2 Dedical Exami	sician: To the best of mer: On the basis of exa se Practioner: To the basis	amination and/or in	vestigation,	n my opinion, death	n occurred a	at the time, date a	and place,	and due to the c	ause(s) and manner sta	ted.
	To th To th Comp		29b. Signature and title of certifier 29c. License number 29d. Date signe							e signed (Month,			
	h		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Typ	e, Print)	r-116			IVIAT	( 21	0010 D 2120	_
-	Ź		Thomas M Pe	mbroke	MD	26	S. Gre	cne s	st. , B.	1hi	nove, M	D 2120	(
	Stat Registra		31. Date filed (Month, Day, Year)	32. Pegistrar	s signature	1							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Parthenia Barnette M March 20, 2010 1347 /Medical 4a. Facility Name (If not institution, give street and number)
Magnolia Center 4b. City. Town, or Location of Death 4c. County of Death Examiner Lanham PG 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-26-1914 9. Birthplace (State or Foreign Country) North Carolina **Funeral** Months Days Hours Min. 578-16-9612 1 □ M 2 🛛 F 95 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho MD PG Lanham Director 1 XYes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8200 Good Luck Rd. 20706 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Black ð 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other this any injury or other traumatic event, It a once. Manager Hot Shoppes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esley John Berry Bessie Davis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Downell Johnson/ Daughter 8150 Lakecrest Dr. #18 Greenbelt, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage mem. Ceme. 03-29-10 Waldorf, md 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Onald Taylor II FII 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE 10 **Physician** UNKNOWN /Medical Due to (or as a consequence of): Examiner ERIPHERAL DISGASE UNKNOWN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed CORONARY UNKNOWN burial-tra resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) the detached 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ be OSTGOMYELITIS OF KNEE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Physician: The certificate perform 1 □ Yes 2 No 2 No 1 🗍 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.0. Division of Vital Records, To the Hospital or Attending within 24 hours after death. To the Funeral Director: After filled in by completely

29a. Certifier

(Check only 29b. Signature and title of

ertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + INA SYED, 7525 GREENWAY CEN

32. Registrar's S

GREENWAY CENTER DRIVE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0063978

29d. Date signed (Month, Day, Year)

GREENBELT,

2010

0 Division of Vital Records

			Please	Type or Prin					-	_	bie.	
		State of Maryland / Department of Health and Mental Hygien  1 - State Registrar  State of Maryland / Department of Health and Mental Hygien  Certificate of Death  Reg. N									110	00120
Physicia	an	1. Decedent's Name	e (First, Middle, L	ast)					2. Date of Dea Month		Year	3. Time of Death
/Medic	al	4a. Facility Name (	f not institution, a	Rosa ve street and number)	Lee	Brice		r Location of Death	3 :	19 20 4c. County		3:45 p ^M
Examin	er		ord N/H				Baltim	ore		na		
Funeral Director		5. Social Security N	-7382	Sex 7. Ag	e (In yrs. las 72		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 4-24-	1937	9. Birthp Coun	lace (State or Foreign try) S.C.
/land		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Limits
ie Mary 8a-f sh	ctor	MD		na	Bal	timo						1 <b>X</b> Yes 2□No
with the	I Dir	10e. Street and Nur 1400 E.		n Street	Apt	504	10f. Zip Code 21	205		10g. Citizen of V US		try?
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in 72 hou "natura	Completed	(Spec	15. Decedent's E city only highest g	ducation ade completed)		(Give F	ent's Usual Occup kind of work done OO NOT use retire	during most of work	ing	16b. Kind of Bu	usiness/Ind	dustry
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ind 2 sho alth and 27 is m		19a. Informant's Na Lavonda		(Type. Print) daughter			,	and Number or Rui				*
ges 1 and 2 tof Health at 16 fitem 27 is or other tra		20a. Method of Dis	position		20b. Plac		sition (Name of natory or other place		Date	20c. Location -		
t. Pag rtmen rtant:		4 ☐ Donation	5 ☐ Other (Spec			inity	7 Cemet	ery 3-25	- 1			
Dan permi Depa Impo any ir		21. Signature of Fu	iperal Service Lice	K. Am			Name and Addre	North	March Avenue			D 21202
		shock, or hea	ırt failure. List oni	nplication that caused one cause on each lin	the death.	Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a Due to (or as	a conseque	nce of):	V	erana -				<del>-</del>
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at the death of by the allen trached for us	hysiciar	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pregnand Other <i>(specify)</i>	су			onth	Day Year
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Physician: The law ruthis certificate has be rail director, page 2 sh	Completed									rmed?	Were auto prior to co death? 1 ∐Yes	psy findings available mpletion of cause of
vican rsician s certifi lirector,	o Be	25. Was case referexaminer? 1 ☐ Yes 2 ☑	/	Hospital:	ant 2 🗆 Ei	B/∩utnation	t 3 DOA Oth	26. Place of Deather:	th <i>(Check only o</i> ome 5  Resid		er /Snaait	
ding Phy h. After this funeral d	on: To	27. Manner of Deat		28a. Date of Inju	ry 2	8b. Time of Injury	28c. Inju			now injury occur		у)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	Certification:	2 Accident 3 Suicide 4 Homicide	investigation  6 Could not determine	be 28e. Place of Inju	ury - At hom c. (Specify)	e, farm, stre		]Yes 2□No	28f. Location (S City or Tow		er or Rura	al Route Number,
lospital thours uneral ely filled		29a. Certifier (Check only	O Line die al Cur	Physician: To the best	£ accounts atta	an am allaw last	cambiamatam in marr	and all and talls with the second	and at the state of the same	alaka alah alah a	mandaliza A.	Also serves (a)
To the k within 2 To the R complet	Medical	one) 29b. Signature and	title of certifier	and manner sta	ated.		29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
1		30. Name and add	ress of nerson who	completed cause of d	eath (Item 9	23a) (Type F	Print)	++2+		0>122	110	0.001
A		31. Date filed (Mon	del l	Shanas	ar's Sign	813	Wall	fram 1	void	o floc	din	11/21/234
Sta Registr		NA	R 2 5 201	and manner sta	A Solgina	par				· · · -		

10-02127 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Peter David Bailey State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 16, 2010 0629 hrs **Medical Examiner** Peter David Bailey 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 140 Bohemia Vista Marina Road Chesapeake City Cecil 9. Birthplace (State or ForeignConneticut 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Days Months Hours Director Dec 8, 1964 45 1 X M 2 F Country) Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County unk 10c. City, Town or Location Iny 1 Yes 2 X No imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examingr must be notified at once. Kingston NC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28504 USA 3405 Sloan Street Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes 4 X Divorced If Yes, Give Year 3 Widowed 1 Yes 2x No specify: Specify: white \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 marine carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Bailey Dolly Combs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Bailey/daughter 3607 Victoria Place; Kingston, NC 28504 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Department o Conation 5 X Other Specify: in state 21. Signature of Funeral Service Licensee ROTATO S Wade 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Raltimore Maryland 21201
all caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart I. Enter the disease, or complication Approximate Interval Physician Between Onset and List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cuse (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit ca UNPENDED AMENDED attending physician for use as the burial -Physician/Medi Division of Vital Records, P.O. Box 68760, IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death page 2 should be detached for use as past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed by 2 Yes 2 No 3 ✔ Probably 4 Unknown Diabetes Mellitus, Kidney Insufficiency Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? Yes 2 V No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director, I 25. Was case referred to medical 26.Place of Death (Check only one) æ Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes ဥ No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number March 17, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State 2. Registrar's Signature Registra

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	_	For State			-				rtment of 11/2010d tificate of			-			gibie.		
Physicia Medic		Registrar  1. Decedent's Name			Η.	V	ame		inoute or	Dour		2. Date of Dea Month	ath	ay g	Year	3. Time o	of Death
Examin		4a. Facility Name (if			eet and num. Richey H	ber)			4b. City, Town,		Death B <b>altin</b>	nore	4	c. Count	y of Death	I/A	
Funeral Director		5. Social Security No.	umber <b>4676</b>	6. Sex			yrs. last birt	thday) Yrs.	If Under 1 Year Months Days		Hrs. Min.	8. Date of Bird (Month, Da Aug 2	y, Year)		Cou	nplace (State Intry) <b>Maryland</b>	
aryland a-f show fied at	ector	Usual Residence of 10a. State Maryland	10b. County	Baltim	ore	100	c. City, Tow	n or Loc		Baltimore						10d. Inside 0	Dity Limits
with the Mi 23a or 28 ust be noti	Funeral Director	10e. Street and Nun	nber						10f. Zip Code	21207	7		10g. C	Ditizen of	What Cou	untry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ò	11. Marital Status  1  Never Marri 3  Xidowed	ied 2 🗆 Mar	12 ried	. Was Dece Armed For 1  Yes If Yes, Give Year or Da	ces? 2 X No	in U.S.	If	Vas Decedent of Yes, specify Cub	an, Mexican, P				14. Race - American Indian, Black, White, etc. Specify: Black			
within 72 hour giene. er than "natu the Medical	Completed	(Spe	15. Decede ecify o <i>nly highe</i> onday (0-12)			4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Employee Public Works				16b.		Business li	ndustry Saltimore			
d be filed of the firked other tic event,	To Be	17. Father's Name (I	17. Father's Name (First, Middle, Last)  William Barnes						18. Mother's Name (First, Middle, Maiden Surname) Hilda Barnes								
nd 2 should selth and N n 27 is ma er trauma		19a. Informant's Na		hip <i>(Type</i> ,	Print)		191		g Address (Stree '19 Langfor						State, Zip	Code)	
Page 1 arment of He tant: If iter		Bullar 2 - Ofernation 3 - Heritoval noni State						ery, crem	prest Veterans Cemetery 03/26/10 C				ion - City or Town, State  Owings Mills, Md.				
permit. Depart Import any inj		21. Signature of Fu	meral Service t	icensee	St	20		22	Name and Addr Estep 1300	ess of Facility  Brothers F  utaw Plac	uner	al Service, Itimore, M	P. A	\ 217			
Physician/ Medical		23a. Pat 1. Enter t shock, or hear Immediate Cause ( disease or condition resulting in death)	rt failure. List o (Final	complicationly one of	cause on eac	the.	death. Do i	w	do I	ing, such as car			rest,			Approxima interval Be Onset and	tween
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be executed sician and burial-transit	al Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death) I	rlying iinjury s	с.			nsequence										
tificate be ng physic as the bu	Medical	IF FEMALE:		d.													
ne death cer / the attendii ched for use	ysician/	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	230	c. If yes, outo 1  Live I 4  Pregr 9  Unkn	Birth 2 🗀 nant at tim	Fetal deat		Ectopic pregnar Other (specify)	ncy					ate of deli onth	very Day	Year
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	Part II. Other signif	ficant condition	1 -	ibuting to de	eath but no	ot resulting	in the u	nderlying cause g	jiven in Part I.		23e. Did to		use con	_	the cause of obably 4	
n: The law re ficate has be n, page 2 sh		25. Was case referre	ad to madical							No. of Part (		1 Yes			prior to c death?	opsy findings ompletion of	
Physicial this certi al directo	: To Be	examiner? 1 Yes 2  27. Manner of Death	No	Hos				utpatien Time of	t 3 🗆 DOA Ot		ing Hor	me 5 🗆 Resid				w Hospiro	ė
ttending I death. tor: After the funer	Certificate:	1 D Natural 2 ☐ Accident 3 ☐ Suicide	5 Pendir Investi 6 Could	gation		h, Day, Ye	ar) i	injury		rk? ☑Yes 2 ☐ No	0	8d. Describe h				15	
oital or A		4 Homicide	determ		buildir	ig, etc. (Sp	oecify)		eet, factory, office			28f. Location (S City or Tow	n, Stat	e)			noer,
the Hosp thin 24 ho the Fune mpleted f	Medical	(Check 2 only one) 3	Medical E	xaminer Nurse F	: On the basi	s of exami	ination and/	or invest	igation, in my opir leath occurred at t	nion, death occur the time, date an	rred at	the time, date a	nd plac e cause	e, and due e(s) and m	ue to the c nanner as s	ause(s) and m stated.	anner stated.
o o o o o		29b. Signature and	utile of certifie	40	AO				29c. Licen	00642	67		29d. D	ate signe	ed (Month)	, Day, Year)	
Stat		30. Name and addre	uen C	who com	pleted caus	e of death	(Item 23a)	(Type, P	rint) Aden A	V. B.	olt,	M0.2	120				

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month March 01014 Brunson 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bathmore Naspital 5401 Old Court ed. ber 6. Sex / 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year) Birthplace (State or Foreign Country) 1□ M 2 F Months Days Hours Min. 214-68-3762 So Carolina Usual Residence of Decedent 10d. Inside City Limits 1∩a State 10h County 10c. City. Town or Location 1 ¥ Yes 2 No Maryland Baltimore **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1914 Gwynn Oak Avenue 21207 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Specify 3 Widowed 4 □ Divorced Rlack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sweetheart Cup Machine Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oscar Brayboy Drucilla Brayboy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Richburg 1914 Gwynn Oak Avenue Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)/ 03/23/10 Windsor Mill, Md. King Memorial Park 21. Signiture of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. 23a. Party. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairly. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy tensio 1 □Yes 2 🗆 No 1 ☐ Yes 25. Was case ref_rred to medical examiner?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

Director

Funeral

Completed by

Be

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Marked Event in a rust be reatified a once.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician; The law requires that the death certificate be executed physiclan and s the burial-trans s been signed by the should be detached certificate After this

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical

Be Completed by

Certification: To

27. Manner of Death

Medical

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar 29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year)

29c. License number

28c. Injury at Work?

1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed of

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

05-6226 Marc Id court Rd Randollstown Maryland

28d. Describe how injury occurred

1 Yes 2 No

1 Natural

3 Suicide

4 Homicide

(Check only one)

2 Accident

5 Pending investigation

6 Could not be

determined

Registrar's Signa

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any linury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physicia /Medica Examine

**Funeral** 

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

-	For State Registrar	-	Certificate of			j. No.	
	1. Decedent's Name (First, Middle, Last)				Date of Death     Month		3. Time of Death
י ו	Aurelia Cunningham				March	24 2010 24 2010	10:30 A.M
r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	1
	Harford Gardens Care and Rehab		Baltim			n/a	
	21.4-26-8594 1 M 2 NF	(In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) 2–19–192	rear) Cou	place (State or Foreign intry)
-	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or	r Location				10d, Inside City Limits
5							1 XYes 2 □ No
222	MD ry/a		Baltimore 10f. Zip Code		10	g. Citizen of What Cou	ıntrv?
5 (	4700 Harford Road		212	14		USA	,
2	11 Marital Status 12. Was Decedent E	ver in U.S.			ecify Yes or No-	14. Race - Amer	ican Indian,
by run	Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ N  1 □ Yes 2 ☑ N  If Yes, Give  Year or Dates:	0	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No	an, Mexican, Puèrto Specify:	Rićan, etc.)	Black, White Specify: Afri	can-American
ошыне	15. Decedent's Education (Specify only highest grade completed)	(G	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	oation during most of work d)	ing   1	6b. Kind of Business/I	ndustry
E	Elementary/Secondary (0-12) College (1-4or 5-	-)	Laborer	,		Homes	
De C	17. Father's Name (First, Middle, Last) unk			18. Mother's Name	e (First, Middle, M	aiden Surname)	
0				Ellnor Cu	nningham		
1	19a. Informant's Name/Relationship (Type. Print)	l l	Mailing Address (Street				lip Code)
1	Charlotte Brewer/Daughter	10	888 Sherwood	Hill Road,	Owings Mill	ls, MD 21117	
Ĩ	20a. Method of Disposition	20b. Place of D cemetery,	isposition (Name of crematory or other pla	ce)	Date 2	0c. Location - City or	Town, State
	1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Cemetery	3-29-		Lansdowne, M	
	21. Signature of Funeral Service Licensee	i l	22. Name and Address 9200 Liberty			Hame P.A. of MD 21133	Balto. Co.
	23a. Pa . Enter the disease, or complications tha caused shock, or heart failure. List only one cause on 23 h lin	the death. Do not	t enter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Immediate Cause (Final disease or condition						Onset and Death
	resulting in death)  Due to (or as a	a consequence of)	emention ASWD				
ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	a consequence of)					
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
EXa	resulting in death) Last Due to (or as a	a consequence of)	):				
S S	d			<del></del>			
	IF FEMALE:			7.51			
lan/	23b. Was decedent pregnant 1 Live birth	2 Fetal death	3 ☐ Ectopic pregnand	:y		23d. Date of del Month	ivery Day Year
Physician/IV	1 ☐ Yes 2 💆 No 4 ☐ Pregnant at 9 ☐ Unknown 9 ☐ Unknown	time of death	5 ☐ Other (specify) _				
	Part II. Other significant conditions contributing to death but	ıt not resulting in t	he underlying cause gi	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Completed by					1 □ Ye	s 2□No 3□Pr	obably 4. Onknown
lete					24a. Was ar	24b. Were au	utopsy findings available
E C					autopsy	y prior to ned2 death? ☑No 1 ☐ Yes	completion of cause of
	25. Was case referred to medical			26. Place of Dea	1 Yes 2 th (Check only one		20110
To Be	examiner? 1 ☐ Yes 2 ☐ Yo Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	eatient 3 DOA Ot	her:		nce 6 □Other (Spe	cify)
	27. Man v of Death 28a. Date of Inju		me of 28c. Inju		28d. Describe ho		
atio	2 Accident investigation			Yes 2 □ No			
III C	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injuit building, etc.	iry - At home, farn c. (Specify)	n, street, factory, office		28f. Location (Str. City or Town	reet and Number or Ri , State)	ural Route Number,
Č							
edical Certification:	29a. Certifier  (Check only one)    Certifying Physician: To the best of and manner starts	examination and					
Ž	29b. Signature and title of certifier			se number		d. Date signed (Mont	th, Day, Year)
	MD Commo		D:	57727		3/24/19	3
	30. Name and address of person who completed cause of d	eath (Item 23a) (T	ype, Print)	57727 n Wor	do.	UD 21	234
е		ar's Signature	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		11/	
ır	MAR 2 5 2010	. A .	hall !				

Sta Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month of Physician/ Shannon Connor Mabe 1 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Sept. 2,1923 Min 1 M 2 X 86 219-14-5266 PA Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Anne Arundel Glen Burnie 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 731 Cotter Road 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No n "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. β 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examir If Yes, Give Year or Dates 1 Yes 2 No Specify. White Specify: 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Procurement Specialist US. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Skidmore Laura Duckworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Virginia Avenue N.W. Glen Burnie MD 21061 Ms Suzie Shannon /Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 27 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem.Park 2010 4 Donation 5 Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Crmeation Services PA 1 2nd Ave.SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate uctive Interval Between Onset and Death Immediate Cause (Final Julmonas Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death ed by the a g Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No this certificate 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to edica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 🗀 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 23 of death (Item 28a) (Type, Print) HOS 七。 ICKS Jed Vge 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Seasons Hospice Randallstown 9. Birthplace (State or Foreign Country) New York 5. Social Security Number if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months 1 X M 2 □ F **Director** 48 219-88-3957 July 18. 1961 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show If a Medical Expedient or mothed at 1 ☐Yes 2 No Director Maryland Ceci1 Colora 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Sterling Nesbit Court 21917 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No δ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Residential/Commercial Elementary/Secondary (0-12) College (1-4or 5+) 03 Proprietor/Electrical Contractor Construction ages 1 and 2 should be filed vent of Health and Mental Hygient of Health and Mental Hygient: If Item 27 is marked other ty or other traumatic event, III. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Cooke, Catherine 2 James Francis Sr. Anne Fitzgerald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>James F. Cooke, Sr./Father</u> 1028 Bosley Road, Cockeysville, Maryland 21030 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Atlantic Crematory 3/27/10 Glen Burnie, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc W. Clary Bryan 10 W. Padonia Road, Timonium, Maryland 23a. Part Y. Enter the disease, or complicating that caused the shick, or heart failure. List only one cause on exchaine. Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediat Caus (Final disease or contion resulting in death) **Physician** /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. signed by the a d be detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No of Vital 1 ☐ Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 1 Yes ₹ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury at Work? Division Hospital or Attending Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: / 2 Accident filled in by the 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 31. Date filed (Month, Day, Year) 32. Registrar's Signa MAR 25 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09127 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician CAROLYN ELAINE CROSS March 19 2010 9:19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Prince Georges Hospital Cheverly 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F Director 579-68-4219 62 July | 25, 1947 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2√ ☐ No MD Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 130 East Mill Ave. 20743 USA Funeral or items, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after i ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or iten ury or other traumatic event, the feation Experimen ury or other traumatic event, the feation Experimen 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. þ Specify: 3 ☐ Widowed 4 🛛 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Attendent Montgomery Cty Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Seymour Thomas 2 Emma Coleman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Capitol Heights, Maryland 20743 Carmen Thomas/Daughter 130 East Mill Ave 20b. Place of Disposition (Name of cemetery, cramatory or other place)
Warren Church
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or conce. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/26/2010 Martinsburg, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Sepsis days /Medical Due to (or as a consequence of): Examiner 6 Weeks h Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Chronic Renal Failure 2 yrs burial-tra resulting in death) Last Due to (or as a consequence of): physician the buria Physician/Medical 2 yrs Hypertension IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the e 1 ☐ Yes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Intracerebral bleeding 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Multiple Cerebro Vascular Accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 K No Seizure Disorder 1 □ Yes 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∏Yes 21√ No 1 Inpatient 2 X ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 ☑ Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely within 2 and manner stated.

Records, Division of Vital or Attending Physician:

Saltimore, Maryland 21215-0036

Box 68760,

P.O.

State Registrar 29b. Signature and

title of

Revathy Murthy, MD

ertifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6130 Landover Rd.

32. Registrat's Signature

29c. License number

Cheverly, Md. 20785

D16273

29d. Date signed (Month, Day, Year)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ MARCH 20°10 12:50 **FDTTH** C. COPPER ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 942 Hammonds Lane Brooklyn Anne Arundel 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 28, 194 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Country) Jest Virginia Hours 218-36-0752 Director 68 West Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Anne Arundel **Baltimore** 1 Yes 2 No 9 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 942 Hammonds Lane 21225 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 K Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Doctor's Office 0 Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Nelson Mildred Stalnacker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8243 Roanoke Court, Severn, Maryland 21144 Dawn K. Moran (Daughter) 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 A Cremation 3 Removal from State Atlantic Crematory or other place. 3/25/2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fine Pervice Licensee Kevin E Fcker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 65Tuc TUE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for se's consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Control of the contro in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, cate has been sig page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed certificate 2 M No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury 1 Yes. 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ROSES52

Smith Dusmus #208 Southers May low

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Sister Mary Angela Donohoe 03 17 2010 7:25a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4130 Maple Avenue Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F 87 Yre Director 199 40 5932 Delaware 07/01/1922 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Itam 27 Is marked other than "netural", or Itams 23s or 28a-f show other traumatic avent. The Medical Examiner must be notified at **Baltimore** Marvland Baltimore 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 U.S.A. 4130 Maple Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Itam 27 Is marked othar than Elementary/Secondary (0-12) Coflege (1-4or 5+) Social Worker Religious Sister 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas F. Donohoe May Ward 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21227 Sister Mary Becker 4130 Maple Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or New Cathedral Cemetery03/22/2010 | Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 rominousa 23a/ Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 4 cute myocar disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical thet IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Cancer Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No this 28a. Date of fnjury (Month, Day Year) 27. Mannet of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Fo the Hospital or Attending within 24 hours after death, Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29b. Signature and title of certifier 028236 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAPPEN AND TOO CEIPE PLANTS BAH, MN 21728 32. Registrar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Janen Boise	-,		1- For State Registrar	Ce	rtificate of Dea		7.0	2UIU	09136
Phys	icia	n/	1. Decedent's Name (First, Middle,Last)				2. Date of Death	1	3. Time of Death
Medical Exa	4111111	er	Darren  4a. Facility Name (if not institution, give s	treet and number)		Sey Jr.  7, Town, or Location of De	Month March 21, 1	2010 4c. County of Death	2323 hrs
-			Sinai Hospital	,		timore		NA	
Fune Direct			5. Social Security Number 6. Sex Unk	7. Age (In yrs.	Mon	nder 1 Year   If Under 24 hths   Days   Hours   N	frs. 8. Date of Birth	(MM/DD/YYYY) 9. Birt Foreig 7 82 Co	
>		- 1	Usual Residence of Decedent		, Town or Location				
Aus wor	:	- 1	MD NA	Toc. City	Baltimor	ce			10d. Inside City Limits 1 X Yes 2 No
daryland 28a-f show	notified at once.	Director	10e. Street and Number		10f. Z	Zip Code	10	g. Citizen of What Cour	itry?
h the N	tile	ַבֿן	3431 Park Heigh	nts Ave		21215		U.S.A	•
ath wit	st be	Funeral	11. Marital Status  1 X Never Married 2 Married	2. Was Decedent Ever in L Armed Forces?		dent of Hispanic Origin? ( cify Cuban, Mexican, Pue		14. Race - Ameri White, etc.	can Indian, Black,
ifter de	ler m	g E	3 Widowed 4 Divorced If	1 Yes 24 No Yes, Give Year r Dates:	1 Yes	2X No specify:		Specify: Bla	ck
hours a			15. Decedent's Education (Specify only	highest grade completed)		al Occupation (Give kind overking life, DO NOT use of		16b. Kind of Business/l	ndustry
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21215-0036 wld be filed within 7 Mental Hygiene. marked other than		Be O	Darren V. Dorses  19a. Informant's Name/Relationship (Type	Sr.	10h Mailing Addro	Rona B	rand	on City on Town Control	7: 0:4:
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re, MC s 1 and 2 sl f Health an			20a. Method of Disposition  1 X Burial 2 Cremation 3	20b.	Place of Disposition (No	ame of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I a Department of He Important: If ite	or other		4 Donation 5 Other Specify:	K	ing Mem.	Pk.Cem. 0			
Baltimo permit. Page Department o	injury		21. Signature of Eunefal Service License	he	22. Name ar	nd Address of Facility Wy FAII West 6 Vabash Ave	lie Funer 38 N. Gid 7 Baltim	al Home. P. more St _{Med}	A. <del>21215</del>
Physicia / Medic			23a. Part I. Enter the disease, or complicate failure. List only one cause on each	ations that caused the death line.	n. Do not enter the mode	e of dying, such as cardia	c or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examin				ultiple Gunshot Wour e to (or as a consequence o					Death
			Sequentially list conditions, b						
	8.	nine	if any, leading to immediate Du cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a consequence o	of);				
Jb = _	nsit	Examiner	events resulting in death) Last Du	e to (or as a consequence o	of):				
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760, icate bo	the bur	Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	gnancy			23d. Date of delivery	
x 68 h certif tending	use as	Physician/	past 12 months?	1 Live birth 4 Pregnant at time of de	2 Fetal death  Other (Sp		nancy	Month D	ay Year
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Reco The lav	page 2	ē					perform	ned? death?	
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of Vi g Physi Rer this	teral di	의	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 28b. Time of Injury	DOA Ourlei 4 Nur 28c. Injury at Work?		esidence 6 Other.	
ion ( tending eath.	the fur	Certification:	1 Natural 5 Pending 2 Accident Investigation	Mar 21, 2010 ear)	1639 hrs	1 Yes 2 ✓ No	Subject shot		
JVIS I or At after d	d in by		3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, street, factor	ry, office building, etc.	or Town, Sta	reet and Number or Rur ate)	al Route Number, City
Lospita 1 ospita 4 hours	ely fille	- 1	4 V Homicide  29a. Certifier A Continue Physician	(Specify) Sidewalk  To the best of my knowled	Ice death occurred at th	ne time, date and place, a		hts , Baltimore, MD	d
Division of Vital Records, P.O. Box 68760,  To the Hospital or brysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	omplete	Medical	one) 2 Medical Examiner: 0	n the basis of examination and manner stated.					
F * F	5	ž	29b. Signature and title of certifier	1.5	25	9c. License number		29d. Date signed (Mon	th, Day, Year)
			Theorline My	King The	mund.	O.C.M.E.	OCME	March 22, 2010	
\			30. Name and address of person who con Theodore M. King, Jr., MD	npleted cause 69 death (Item Assistant Medical)	1.	Penn Street, Baltimo	ore, MD 21201		
Red	Sta	~	31. Date filed (Month, Day Year)	32. Registar's Signal	alle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 19^{ay} 20 Y 0 Lynn Dingman 8:26 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number **Funeral** . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 🗆 M 2 🛣 F Months Days Hours Min (Month, Day, 05/01/ Washington, Director 220-46-7013 63 1946 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location Funeral Director 10d, Inside City Limits MD Howard Columbia 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11320 Buckleberry Path 21044 U.S.A. ?7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 0 à 1 Never Married 2 X Married Maryland 21215-0036 If Yes Give ☐ Yes 2 🔀 No 3 Divorced 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) should be filed with and Mental Hygien 7 is marked other th Manager Telecommunication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dingman Halliday Evora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a David Willemain / Husband 11320 Buckleberry Path, Columbia, MD 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 03/23/2010 Hanover, Maryland 21. Signature Funeral Service License 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Interval Between Immediate Cause (Final Physician/ Onset and Death Peacs Ancrea Medical resulting in death) Examiner to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-1 Physician/Medical Box 68760 as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Live Bertal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death Month Records, P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director. After this certificate h completed filled in by the funeral director, page death? Yes 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident 2 | No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of curred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 MI

DHMH 17 Rev 7/2009

State Registrar Registrar's Signati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:50 P.M Richard John Fowler, March 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Hammonds Lane Anne Arundel Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F 85 (Month, Day, Year) 03/11/1925 Maryland 219 12 7646 Director Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director N/A 1 🛚 Yes 2 🗆 No Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4210 Morrison Court U.S.A. 21226 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced WW II Completed White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Maintenance Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter K. Fowler Mary Agnes Cain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25427 19a. Informant's Name/Relationship (Type, Print) Karen Schultz / Daughter 172 Vera Green Drive Hedgesville, West Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 5 1 A Burial 2 Cremation 3 Removal from State 03/22/2010 Crownsville, Maryland injury o 4 Donation 5 Other (Specify) MD State Veteran Cem. 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani disease or condition Medical resulting in death) Due to (* as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-trans attending physician and Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 🔀 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? To the Funeral Director: After this certificate of completed filled in by the funeral director, page 1 🗌 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 2 🗷 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ∠ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title

State Registrar Oakwood

Road 103

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

k.Ambalavanar

MAR 25 2010

31. Date filed (Month, Day, Year)

7845

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bonnie G. Fouch March 22. ^D2010 10:49 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1700 Ridgely Garth Lutherville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 22 Social Security Number 7. Age (In vrs. last birthday, **Funeral** Country) Hours 1 M 2 X F Director 233-60-3791 69 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Max Yes 2 ☐ No W.V. Berkeley Martinsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 216 Surrey Court 25401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Mamied ☐ Yes 2 No þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Sirbaugh Mamie Dietrick permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Hodge 368 Elk Branch Rd. Daughter Hedesville, WV 25427 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖳 Burial 2 🗌 Cremation 3 🔀 Removal from State cemetery, crematory or other place) Rosedale Cemetery 4 Donation 5 Other (Specify) Martinsburg, W. V. 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland
3631 Falls Roa Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsectionne of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending housing and the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached to g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Hospital 2 **N**No မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) NAWHTERS HOME 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pendino injury Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a D64395 MARCH 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N CHARLES ST. SUITE 4105 BALTIMORE, MB 21204 DANIEUE DOBERMAN, MO 0701 31. Date filed (Month, Day, Year) State MAR 25 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Marrch 2010 рм J. Franke 9:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mercy Ridge Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** ^{Year)}1922 Days Sept 23 1 X M 2 🗆 F Months Hours Director 87 Maryland 218-18-5266 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Md. Timonium 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Rd. 21093 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married δ 21215-0036 Yes Give 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) +2 Contruction Manager Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Franke Anna G. Breutting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10.8 Mr. William J. Franke/ Son 511 Murdock Rd. Baltimore, Md. 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 3-26-10 Towson, Md. 22. Name and Address RUCK 1050 21. Signature Funeral Sen ce Licen Towson Funeral Home, York Rd. Towson, Md. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DMO. disease or condition Medical resulting in death) Due to (or as a consequence Examiner ease < a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trans! that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1/X Yes 2 No 3 Probably 4 Unknown within 24 hours after death. To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence of Other (Specify) Hospital: Other: ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accider 5  $\square$  Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praction on T. the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Praction on T. the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Praction on T. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Praction on T. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Praction on T. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Praction on T. the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation, in my opinion of the basis of examination and/or investigation in the basis of examination and or investigation in the basis of examination and/or investigation in the basis of examination and or investiga (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed dause of death (Item 23a) Type, Print) 300 aver 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH G901 3/25/2010 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No .--1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 2010 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital N/A **Baltimore City** 6. Sex 1 M M 2 □ F 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1171971941 218-36-9823 <del>69</del> 68 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show aţ Director 1 ☐ Yes aX No Examiner must be notified MONTGOMERY **BETHESDA** MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code ō items 23a Funeral 4924 WESTERN AVENUE 20816 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 💢 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No à Specify: WHITE 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If Item 27 is marked other thar any injury or other traumatic event, the Monce. ATTORNEY AT LAW LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FOX **ABRAHAM JEAN** 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LESLIE STERMAN/WIFE 4924 WESTERN AVENUE, BETHESDA, MD 20a. Method of Disposition
1 Bunial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State BETH EL MEMORIAL PK 3/24/2010 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Woll 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IV **Physician** Hage (una disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 🗌 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 X Inpatient Other 1 ☐ Yes 2 No 3 □ DOA 4  $\square$  Nursing Home ၉ 2 ER/Outpatient 5 Residence 6 Other (Specify) this 28a Date of Injury 28c. Injury at Work? 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation rector: After M 1 🗌 Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined after ( **Direc** 4 Homicide Hospital 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the F the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zhay 600 North Wolfe St, Baltimore, MD, 21287 - luichun 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 25

DHMH 17 Rev 1/2001

Registrar

			POI .	epartment of Health and N Ce <i>rtificate of Death</i>	nentai mygiei Reg.		
	Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Medic		Ada Mae Gilliam			20, 2010	2130A-M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
2500	Funeral		Prince Georges Community Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Cheverly  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Geo	rge's
	Director		1 T M 2 187 E	rs. Months Days Hours Min.	8-12-1940	or) Coun NC	try)
	yland -f show ed at	Director	10a. State 10b. County 10c. City, Town	or Location		1	0d. Inside City Limits
	e Ma r 28a notifi	Dire	MD Prince George's Capit	tol Heights 10f. Zip Code	40		1XX Yes 2 □ No
	ith th	la I		·	lug.	Citizen of What Cour	ntry ?
	ems r mu	Funeral	328 Possum Court  11. Marital Status  12. Was Decedent Ever in U.S.	20743  13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Americ	an Indian.
336	filed within 72 hours after death with the Maryland tal Hygiene. All Hygiene. other than "natural", or items 23a or 28a-f show event, th. Medical Extrainer must be notified at.	≦	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced  Armed Forces?  1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐xNo Specify:	Rican, etc.)	Black, White,	
Maryland 21215-0036	72 hours "natur edical E	Completed	15. Decedent's Education 16a. I (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of worki	ing 16b	b. Kind of Business Inc	dustry
12	ithin 7 ene. • than • than	Son	Elementary/Seconday (0-12) College (1-4 or 5+)	ife. DO NOT use retired)	l ci	hildrens H	ospital
D	led w Hygi other	Be	17. Father's Name (First, Middle, Last)	vironmental Service 18. Mother's Name	e (First, Middle, Maid		обриса
lan	I be filed v lental Hyg rked othe tic event,	은	George Herbert Speight		Johnson	,	
a _Z	1 and 2 should be file of Health and Mental I item 27 is marked o other traumatic eve			Mailing Address (Street and Number or Rura	~	or Town, State, Zip C	Code)
Σ	nd 2 s ealth a n 27 i		Thomas Gilliam, Sr./Son 59	902 St. Moritz Dr.	Temple Hi	lls, Maryl	and 20748
ore	of Heal of Heal of item ?		20a. Method of Disposition 20b. Place of	Disposition (Name of crematory or other place)	Date 20c	. Location - City or To	wn, State
Ĕ	Page ment tant:	,		light Cemetery 3/27	/2010 Gre	een Co., N	orth Caroli
Baltimore,	permit. Page 1 a Department of the limportant: If ite any injury or ot once.		21. Signature of Fyneral Service Licensee	22. Name and Address of Facility Mar 4308 Suitland Rd			of Marylan 20746
			23a. Part 1. Enter the disease, or complications that caused the death. Do no			Tidi y zana	Approximate
P	nysician/	8 8	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	my or ARD. A	TWEAM	com	Interval Between Onset and Death
	Medical		resulting in death)  a.  Due to (or as a consequence of	):	AT CIT	01700	
	Examiner	L	Sequentially list conditions, b. MCDB3	MYOCARDIA OCIC ACIDO	813		
	i d	Examiner	in any, reading to immediate cause. Enter Underlying	).			
b.	and and trans	xan	Cause (Disease or linjury that initiated events c	3.			
	cate be executed physician and s the burial-transit	cal	Jeens (or accessed assessed	,			
9		ledical	<b>a</b>				
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  Within 24 hours after death.  To the Funcarial Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as it completed filled in by the funeral director, page 2 should be detached for use as it is a second to the funeral director.	Physician/N	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3		23d. Date of delive Month	ery Day Year
S, P.O	ires that the signed by detact	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to th	ne cause of death? Dably 4 ☑ Unknown
Division of Vital Records,	ie law requ e has beer ige 2 shoul	Completed			24a. Was an autopsy performed	prior to con death?	osy findings available mpletion of cause of
r (	in; Th tificat or, pa	Be C	25. Was case referred to medical	26. Place of Death (Check	1   Yes 2	No 1 ☐ Yes	2 ⊔ No
<u>ב</u> י	ysicie is cer direct	To B	examiner?  1  Yes 2 No Hospital:  1 Inpatient 2 ER/Out	Other:		6 Other (Specify	)
Ö 1	ng Ph ter thi neral		27. Manner of Death 28a. Date of injury 28b. Tit		28d. Describe how in		
0	endir eath. or: Af the fur	fica	2 Accident Investigation	M 1 Yes 2 No			
	l or Att after d Directa I in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
_	Hospita 24 hours Funeral eted fillec	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, do Check 2 Medical Examiner: On the basis of examination and/or	investigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the cal	use(s) and manner stated.
:	o the vithin o the ompli	Σ	only one) 3- Certifying Nurse Practioner: To the best of my knowle 29b. Signature and title of certifier	dge, death occurred at the time, date and place 29c. License number		se(s) and manner as sta Date signed (Month, A	
	- 5 - 0		I Della	D0055703		3/20/	10
	L		30. Name and address of person who completed cause of death (Item 23a) (T)			101	· 
	3		Raymond Thos Benack 3001 Hospital	Drive Cheverly, Ma	ryland 20	0785	
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ale			
	Registra	ar	MAR 25 2010 Graye A. 190				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State	ate of Maryi		artment of tificate of		allu i	vienta	і нус		eg. No.	201	0 0	1913.
Physicia		Registrar 1. Decedent's Name (First, Midd	le,Last)						2.	Date of Deal	th		3. Time	of Death
dical Examir		Sonya Yvette	Groover						į,	Month March 18,	Day 2010	Year	191	5 hrs
		4a. Facility Name (if not institution		umber)	4	b. City, Town	, or Loc	ation of D				ounty of D	eath	
1		Washington Adventis	t Hospital			Takoma	Park				Moi	ntgomer	у	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1	Year I	f Under 2	4Hrs.	8. Date of Bir	th(MM/DD		Birthplace (	State or
Director		01= 06 1650	1 M 2X F	42	Yrs.	Months	Days	Hours	Min.	04/05	/1967	Fo	reign Country)	DC
	- }-	217-06-1650 Usual Residence of Decedent	, NI 241 I	42	, 115.					04/05/	/150/			
any	H	10a. State 10b. County		10c. City.	Town or Location	on							10d. In:	side City Limits
<b>≜</b>													1 🛛	res 2 No
Aaryland 28a-f show 1 at once.	희	MD Montg	omery	Tak	koma Par					T.				
Mari 288	Director	10e. Street and Number				10f. Zip Cod	le			1	0g. Citizen	or what (	Jountry?	
h the	ΞΙ	815 Hayward Av	enue			209	12				US	A		
ms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.		Decedent of				ify Yes or No	- 14.	Race - Ar White, et	merican India	an, Black,
death rr ite nust	Š۱	1 X Never Married 2 M	larried 1 Yes	2 X No	11 16	es, specify Gu	iban, ivie	exican, Ft	Jerto Ki	can, etc.)		vvriite, et	C.	
al", o	ᆰ	3 Widowed 4 Div	orced If Yes, Give Yes	ar	1	Yes 2 X	No sp	ecify:			Sp	ecify: B	lack	
ours a		15. Decedent's Education (Spe	cify only highest gra	de completed)	16a. Decedent						16b. Kind	of Busine	ss/Industry	
72 ho	왕	Elementary/Secondary (0-12)	College (	1-4 or 5+)	during mo	st of working	lite. DO	NOT use	e retired	1)				
O36	림	12th			Divers	sity D	eve1	opme	nt.	Spec.	US	Posta	al Ser	vice
5-0036 led within 7 Hygiene. other than the Medica	Completed	17. Father's Name (First, Middle	, Last)		Divers	JIC, D	18.N	Nother's N	lame (F	irst, Middle, I	vlaiden Su	name)		
215 be file ntal H rked ent, ti	Be	Clarence Groov	or				N	etti	e R	2050				
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other that artic event, the Med	<u>ا</u> ت.	19a. Informant's Name/Relations	ship (Type, Print )		19b. Mailing	Address (S					nber, City o	or Town, S	tate, Zip Coo	te)
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once	٦,	Clarence Groove	r/Father		815 Ha	awward	Δπο	Тэ	kom	a Park	Mar	v1an	d 209	12
ore, MI s 1 and 2 s of Health a If item 27	- 1	20a. Method of Disposition	I/Father	20b. F	Place of Disposit	tion (Name o	cemete	ry,		a rark Date			y or Town, S	
Baltimore, permit. Pages 1 at Department of Hee Important: If ite	Ш	1 X Burial 2 Cremation	n 3 Removal fi	rom State	crematory or oth	er place)								
Pag Pag ment tant:	Щ	4 Donation 5 Other S	pecify:	Man	ryland N					7/2010				
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	ı	21. Signature of Funeral Service	Licensee 7	1. 1										Maryla
<b>m</b> %⊊≣≣	- 14	Victorine,	C. Woo.	de	430	08 Sui	tlan	id Rd	S	uitlan	d, Ma	ryla	nd 20	746
Physician	$\neg$	23a. Part I. Enter the disease, or		aused the death.	Do not enter th	e mode of dy	ing, suc	h as card	iac or re	espiratory arro	est, shock,	or heart		ximate Interval
<b>Medical</b>	- 1	failure. List only one cause		tonativo	cordio	70001	or d	li con					Betwe	een Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)		consequence of		vascur	ar u	isea	ise				-	
	- 1	Commentate statements and	b.											
	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence of	f):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С.										- 3	
8 = 1	<u>s</u>	events resulting in death) Last	Due to (or as a	a consequence of	):								- 1	
executed an and al - transi	ᆲ		d											
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x 68 th certif ttending r use as	ician/Me	23b. Was decedent pregnant in the past 12 months?	the 1 Live to 4 Pregr	nant at time of de	oth -			Ectopic pr	egnanc	y 				Year
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1 of Vital Records, P.O. B ing Physician: The law requires that the d After this certificate has been signed by the funeral director, page 2 should be detached	Medical Certification: To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2  No 9  Un  Part II. Other significant condit  25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Penical Penic	known 1 Live to 4 Pregress Renown 9 Unknown 1 Live to 4 Pregress Renown 1 Live to 4 Pregress Renown 1 Live to 1 Live	Inpatient 2 V  or of Injury - At hose of examination are stated.	ER/Outpatient 28b. Time of In ome, farm, street	26.P 3 DOA siyury 28c. 1 t, factory, offi	se giver  lace of [ Oth Oth Injury at Yes ce buildi	Death (Cref4 N Work? 2 Noting, etc.	28 28 and durred at the	23e. Did to  1 Yes  24a. Was autop perform  1 Yes  y one)  Home 5 Bd. Describe In the cause of Town, See to the cause of t	Mobacco uses 2 No an sy med? 2 No Residence now injury.	contribute o 3 1 24b. Were prior deatt 1 2 6 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Day  e to the cause  Probably 4  e autopsy fin  to completic  not yes  Yes  where  r Rural Route  stated  o the cause  (Month, Day,	e of death?  Unknown dings available n of cause of 2 No No

DHMH 17 Rev 1/2001 OCME 2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last, 2. Date of Death 00:40 AM **Physician** Month. ter Anthon cev /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 64 641 MARYLAND NOV **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 No Director CARROLL mo WESTMINSTER 10e. Street and Number 10g. Citizen of What Country? ö JSA 21157 23a WESTMINSTER PIE Funeral items : 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify. 2 Specify: WHITE 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) TONY GREEN Elementary/Secondary (0-12) other than College (1-4 or 5+) TECHNICIAN HEATING & COULING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be is marked PALMER WALTER GREEN 1. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KELLY ANN GREEN/WIFE item 27 i 321 OLD WESTMINSTER PIKE WESTMINSTER MU 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If iter any injury or oth once. 1 🗶 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/26/2010 WESTMINSTER, MD 4 □ Donation 5 □ Other (Specify) BRANCH CEM 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.N Zum BWN FIH & MON 6 ELDENSURG-MO 2/784 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final bleed **Physician** Gastro Intestinal disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 2 □ No signed by t Id be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 2 1 Yes or Attending Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ 2 ER/Outpatient 3 DOA 6 Other (Specify) မ funeral 27. Manger of Death 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: (Month, Day Year) After 1 Natural 2 Accident 5 Pending investigation Injury 1 Tes 2 No illed in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, 24 hours a Funeral C Hospital

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 34

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

29a. Certifier (check only

within 24 hox To the Fune completely fi

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death **Physician** 8:30 AM March Alberta В. Gamble 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Roland Park Place **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 13 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours ^{Year)} 1926 Days 1 □ M 2 K F 83 Minnesota 266-32-8906 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Mary land N/A Baltimore 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 3704 N. Charles St. 21218 Apt. 1106 U.S.A. 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify White ò 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sculpturist Sculpting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otto I Bergh S Hovey Frances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3704 N. Charles St.Apt. 1106 Baltimore, MD. 21218 item 27 i William Gamble / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iten
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/24/2010 Hilltop Svc. Corp. Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acuse stuke Muth **Physician** tours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4⊡Pregnant at time of death 5 Other (specify) P.0. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ Librillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 27. Man r of Death 1 Natural Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After I or Attending F after death. 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 17 Gabelle Mac D13657 Varch 22, 2010

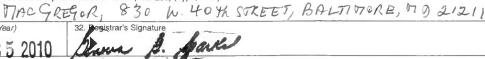
10 V

State

Registrar

31. Date filed (Month, Day, Year)

MISMELLE



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death -Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Day 2010 Physician/ 2:304 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DW SO 8. Date of Birth (Month, Day, Ye 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Hours Min. Months 58 Yrs. **Director** or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Completed lac Year or Dates 15. Decedent's Education 16a, Decedent's Usual Decupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Nam မ Page 1 and 2 should be ment of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Metho of Disposition 20b. Place of Disposition (Name of connetery, crematory or other place) 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Va USAA 21. Signature of Funeral Service Licensee Areene Funeral Services 23a. Part 1. Enter h disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER disease or condition NO montas Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exam or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death signed by the a Id be detached f 2 🗌 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Wunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 2 No 1 Yes 25. Was case referred to medical of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 6 X Other (Specify) NUSPILE 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work Division 1 Yes 2 Accident 2 No Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HMUES 31. Date filed (Month, Day, Year) legistrar's Signature State 25 Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rajahnthon Hayn		State of Maryland / Department of He -For State Certificate of De			2010	09141
Physicia Medical Examin	n/	tegistrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month March 14,		3. Time of Death 1925 hrs
The state of the s		4a. Facility Name (if not institution, give street and number)  4b. C	City, Town, or Location of Dea		4c. County of Deat	
A. Europol			altimore Under 1 Year   If Under 24H	frs 8 Date of Birth	N/A	rthplace (State or Foreign
Funeral Director			Months Days Hours M		C	ountry)
any	ŀ	Usual Residence of Decedent  10a, State 10b. County 10c. City, Town or Location				10d. Inside City Limits
<b>*</b>	۱,	Md. Baltimore Owings M	Mills			1 Yes 2 No
hours after death with the Maryland "natural", nr items 23a nr 28a-f show Examiner must he notified at once.	Director		f. Zip Code	10	g. Citizen of What Cou	untry?
th the 23s or notifie			21117		USA	
eath wi	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, s	ecedent of Hispanic Origin? ( specify Cuban, Mexican, Puer		14. Race - Ame White, etc.	rican Indian, Black,
	by F.	3 Widowed 4 Divorced If Yes, give Year 1 Yes	s 2X No specify:		Specify:	Black
5-0036 led within 72 hours after thygiene. other than "natural",		during most o	sual Occupation (Give kind o		16b, Kind of Business	/Industry
24	E E	Elementary/Secondary (0-12) College (1-4 or 5+)		,	Infant	
5-0036 led within 72 Hygiene. other than "	Completed	0 Infant 17. Father's Name (First, Middle, Last)		me (First, Middle, M		
	Be	Solomene Smith	Lakes			
imore, MD 2121 Pages I and 2 should be fi nent of Health and Mental I lant: If item 27 is marked or other traumatic event,	P		dress (Street and Number of			
ore, MD ; ies I and 2 shou of Health and 1 If item 27 is 1 ther traumatic	1	20a. Method of Disposition 20b. Place of Disposition		Date Date	20c. Location - City o	
nord		1 XBurial 2 Cremation 3 Removal from State crematory or other p	rial Cem. 3	/25/10	Windsor	Mill Md
Baltimore permit. Pages 1 a Department of He Important: If it	ł		and Address of Facility ep Brothers			
= ====	4	11300	<u>O Eutaw Pla</u>	ce, Bait	ımore, Ma	. 21217
Physician /Medical		23a. Part I. Entéd the disease, or complications that caused the death. Do not enter the me failure. List only one cause on each line.	ode of dying, such as cardiac	c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
xaminer	1	Immediate Cause (Final disease or condition resulting in death)  a Head Injury  Due to (or as a consequence of):				Death
	.	Sequentially list conditions, b				
	[₹	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause c.				
d d	Exan	events resulting in death) Last Due to (or as a consequence of):				1
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be be		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	
lox 6876( eath certificate : attending phys	E I	3b. Was decedent pregnant in the past 12 months?	eath 3 Ectopic pregr	nancy		Day Year
Records, P.O. Box 6876. The law requires that the death certificate teath be attending play that been signed by the attending play page 2 should be detached for use as the last page 2.	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)			ł
O. By at the de de by the stached f	- 1	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
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Rec The la icate h	틹			perform 1 ✓ Yes 2		es 2 No
	8	25. Was case referred to medical examiner? Hospital: 4 Innation: 3 FR/Outpation: 3	26 Place of Death (Chec			
# # # # # # # # # # # # # # # # # # #	읽	27. Manner of Death 28a. Date of Injury 28b. Time of Injury			Residence 6 V Othe	er: Scene
	Certification:	1 Natural 5 Pending FOUND: FOUND: 1925 hrs	1 Yes 2 ✔ No	Subject assa		
Division safter death. In Director: A	<u>≅</u>	2 Accident Investigation War 14, 2010 1925 hrs 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac	ctory, office building, etc.	28f. Location (St or Town, Sta		ural Route Number, City
Dapital hours a	5	4 Homicide determined (Specify) Found in woods		Found, 3100 bl	k Swan Drive, Balti	
Division  To the Hospital or Attendit within 24 hours after death. To the Fineral Director: A  To completely filled in by the fi	edica	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, i				
To To com	ĕ	and manner stated.  29b. Signature and title of certifier	29c. License number	T	29d. Date signed (Mo	
		Cercl Hallen	O.C.M.E.		March 15, 2010	
	ŀ	30. Name and address of person who completed cause of death (Item 23a)				
LV			et, Baltimore, MD 212	201		
Sta Registr	-	31. Date filed (Month, Day, Year)  32. Registrar's Signature	w.			
	_	ANN GO CUIU	<del>-</del>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland 2D 64777 Pot 168 lth and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Ernest John Frederick Hoffman 2. Date of Death **Physician** Month Year John Preservele 90/fm 2010 MARCH 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Land CIT / If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/15/1925 4b. City-Town, or Location of Death 4c. County of Death Examiner Hospita (prhor 5. Social Security Number Birthplace (State or Foreign Country)
 MD 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 85 219-12-6055 Yrs. MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or Items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Event or ust be retilled anone. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore **Funeral Director** 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4412 Norfen Road 21227 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 △ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 າ 943 1946 Specify: White 1 □Yes 2 No þ If Yes, Give Year or Dates: Specify: 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Machinist 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William D. Hoffman Henrietta Schildwaechter 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Hoffman / Son 4412 Norfen Road, Baltimore, MD 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 3/27/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 MARI SA M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIAL mmedint disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner myocordis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Funeral Director: After this certificate has been signed by the attending physician and ately filled in by the funeral director, page 2 should be detached for use as the burial-transit Conversion Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Denenh 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0061438

Registrar
DHMH 17 Rev 1/2001

State

10

300 1 South Hanever St Baltime MD 21205

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MNIDIZEW

MAR 25

31. Date filed (Month, Day, Year)

BUKOVITZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7 Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1043 Dockser Drive Crownsville Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 ₹ M 2 □ F 0876271937 214-66-0326 Director 52 Usual Residence of Decedent show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified MD Anne Arundel Crownsville 28a-f 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r Funeral 1043 Dockser Drive 21032 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married ō Completed by 1 Yes 2 No and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: 3 Widowed 4X Divorced White Year or Dates. event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printer Printing and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Johnston SR Gail Swanson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $7682\ Quarterfield\ Road\ Glen\ Burnie,\ MD\ 21061$ Gail Johnston Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 03/27/2010 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hardesty Funeral Home P.A. Jaky 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one complications on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Examine attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death
Unknown Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) al or Attending Pl s after death. I Director: After th 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best Mmy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day Year, 30. Name and address of p 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 24^{pay} 20 ÎÖ :30 A Diana Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** <u>Tate House Hospice</u> Anne Arundel Linthicum Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □XF Months Days Hours Min October 27,1934 Maryland Director 75 213-32-9253 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛂 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2936 Bristol Channel Court 21122 U.S.A 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Senior Analyst Balto-Housing Authority Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic Joseph Roemer, Sr. Catherine Hecker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen M. Murk(Sister) 4710 Everlea Court Preston, Maryland 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Donation 5 C Other (Specify) 03/27/10 Cedar Hill Cemetery Brooklyn Park, Maryland 22. Name and Address of Facility, McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Signature of Fuperal Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading 1: mind clucause. Enter Underlying Cause (Disease or linjury that in literal water). Examine Due to for as a consequence of ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12-months? Month Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant 9 ☐ Unknown signed by the sign of the sign of the sign of the sign of the detached for the sign of the 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law Jas page 2 performed After this certificate I 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 0 456 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending work? death. 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

OSPITAL

GLEN BURNIE MA DIBO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month 30 PM 2010 John Christian Kubilius /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death, Examiner Kosedal Klin Square Baltimore Fran HOSPITA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. ast birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months 1 X M 2 □ F Yrs Director 213-84-9055 Maryland 37 1/23/1973 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 ☐ Yes 2 X No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9410 Windpine Road Funeral 21220 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 ☐ Married 1 ∐Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paint Manufacturing Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ John Kubilius, Jr. Kathleen Jo Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>John Kubilius, Jr.</u> 710 Rockaway Beach Avenue Exxex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Holly Hill Mem. Gard. Middle River, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Fastern Avenue 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. First Indelying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate be executed use as the burial-trans and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 No detached 9 Unknown 9 Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s peen si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate of Vital 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient After this ( funeral dir P 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 □No r death. neral Director: / 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person uyen 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

John Kubilly

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 March 15, 9:45 AM William Lockwood Μ. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 10002 Puritan Way Montgomery Damascus 8. Date of Birth (Month, Day, Year Aug. 17, 1 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1√2 M 2□ F 147-14-2912 87 1922 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Montgomery Damascus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20872 USA 10002 Puritan Wqy

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

(Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes 2 No

16a. Decedent's Usual Occupation

Chemist

death with the Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any liquy or other traumatic event once.

Maryland 21215-0036

Baltimore,

P.0.

Records,

Division or Vital

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be ည 11. Marital Status

1 ☐ Never Married 2 ☐ Married

15. Decedent's Education (Specify only highest grade completed)

1 → Burial 2 □ Cremation 3 □ Removal from State

3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

12

William Lockwood

4 Donation 5 Other (Specify)

19a. Informant's Name/Relationship (Type. Print)

17. Father's Name (First, Middle, Last)

Barbara Lockwood

20a. Method of Disposition

**Funeral** 

Director

**Physician** /Medical **Examiner** 

and burial-trar attending physician for use as the buria ed by the a signed by t page 2 should certificate this After death.

certificate be executed in by the funeral after death Director: Hospital or 24 hours a completely filled To the within 2

20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Memorial Park 3-20-2010 Paramus, NJ 21. Signature of Pulleral Service Licensee 22. Name and Address of Facility Browning-Forshay Funeral Home 557 Lafayette Ave., Hawthorne, NJ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD Due to (or as a consequence of): pidemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c insequence of) Examiner pertension Due to for as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an autopsy perform 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certific 29c. License number

12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes. Give

College (1-4or 5+)

4

If Yes, Give Year or Dates: 1943-45

29d. Date signed (Month, Day, Year) 2010

14. Race - American Indian.

White

Approximate Interval Between Onset and Death

20 Years

years

Black, White, etc.

16b. Kind of Business/Industry

Chemica1

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

18. Mother's Name (First, Middle, Maiden Surname)

Anna Weston

6 Mansfield Village, Hackettstown, NJ

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Benjamin t. apoi

9815 Man Street Damasers, MD 20872

31. Date filed (Month, Day, Year)

32; Registrar's Signature

R

State Registrar

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2010 March 15, **Physician** Luck Heywood John 528 М /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Own Place College Park PG 6. Sex 1**∆** M 2□ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06–19–1946 9. Birthplace (State or Foreign Country)
Wash DC 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Min. Months Days Hours 219-80-1027 63 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its M-dical Evan, for must be notified any injury or other traumatic event, Its M-dical Evan, for must be notified anone. 10a. State 10b. County PG MD College Park 1 Yes 2 No Director 10e. Street and Number 10207 Baltimore Ave. #8110 10f. Zip Code 20740 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2. Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Black Specify: <u>ک</u> 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Heywood Luck Jesse Della Seals ပ 19a. Informant's Name/Relationship (Type. Print)
Maria Taylor/Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6904 Decatur Pl. Hyattsville, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale Pk Crematory 3-26-2010 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licenses 22. Name and Address of FacilityRonald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 Konal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Se osi 03/06/10 disease or condition resulting in death) > /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 1 Yes 2 □ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending within 24 hours atter usus...

To the Funeral Director: Aff 1 ☐Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A YEH - Varnum Street NE. Washington DC 200H AHETET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Registrar

MAR 25 2010

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ 101	of Maryland / Depa	artment of Healt		ntal Hygie	ne	
		State Registrar		Reg. No 2 1 1 1 9 4 9				
Physici	an/	1. Decedent's Name (First, Middle, Last)				Date of Death Month	22, 2010	3. Time of Death
Med		Regina F. Lo  4a. Facility Name (if not institution, give street and nu.	gue	4b. City, Town, or Locati		March 2		2:42 P. M
Exami	ner	719 Maiden Choice Lane	,	Catonsvi			4c. County of Dear	
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Un	nder 24 Hrs. 8.	Date of Birth	g, Bir	thplace (State or Foreign
Director		167-01-6281 1 □ M 2 🛣 F	93 Yrs.	Months Days Hou	ırs Min. A	(Month, Day Ye	1916 Per	insylvania
p om d		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo				-	10d. Inside City Limits
ırylan a-f sh	cto							1 🗆 Yes 2 🗶 No
or 28%	Director	Md Baltimore  10e. Street and Number	Cato	nsville 10f. Zip Code		100	. Citizen of What Co	
with th	iral	719 Maiden Choice Lane	HR322	21228		_	SA	ountry:
eath v	Funeral	11. Marital Status 12. Was Dec	edent Ever in U.S. 13. \	Vas Decedent of Hispanic			14. Race - Ame	
fter of to a mine		Armed F- 1 Never Married 2 Married 1 Yes, Gi	2 <b>X</b> No	f Yes, specify Cuban, Mex □ Yes 2 🌁 No S <i>p</i> e		an, etc.)	Black, Whit	e, etc. hite
21215-0036 within 72 hours after giene iner than "natural", o ; the Medical Exam	Completed by	3 Nidowed 4 Li Divorced Year or D	ates.		icny:		Specify:	
15-72 hc 72 hc 16-dic	lgi	15. Decedent's Education (Specify only highest grade completed	(Give	lent's Usual Occupation kind of work done during r O NOT use retired)	most of working	16	b. Kind of Business	Industry
r than	S	Elementary/Seconday (0-12) College (	1-4 OF 5+)	e Manager		c	onstructi	lon
d Hyg	Be	17. Father's Name (First, Middle, Last)			Nother's Name (Fi	rst, Middle, Maid	den Sumame)	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and a more.	욘	Wladislaw Fudala		Jo	osephine	e Borkow	rska	
Shoulk and h is ma	ļ,	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Nu ntern Court	imber or Rural Ro	oute Number, Cit	y or Town, State, Zi	p Code)
P, N und 2 lealth im 27		Joanne Logue Daughte			Unit 20	74; 11110	TILUM, FID	21095
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once,		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date		c. Location - City or	
ting it. Pag rtant rtant		4 Donation 5 Other (Specify)	Dulaney V	alley Mem.	3/25/2	010 Ti	monium, M	
Ball permit Depar Impor any in		21. Sign of re of Full eral School Licenses	Fu Fu	Name and Address of Fa Ineral Home 30 Edmondso	of Cator	ling Asn isville,	Inc.	m ologo
_		23a. Part 1. Enter the disease, or complications that	caused the death. Do not enter	30 Edmondso: er the mode of dving, such	n Avenue n as cardiac or res	spiratory arrest.	isville, N	Approximate
Fnysician		shock, or heart failure. List only one cause on e Immediate Cause (Final	ach line	he i mes s		A	2	Interval Between Onset and Death
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ecuted and I-transi	xam	Cause (Disease or iinjury that initiated events c.						
760 Kinate be executed physician and the burial-transit	a E	resulting in death) Last Due to	(or as a consequence of):					
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ox 687 sath certifice attending p	Ž		tcome of pregnancy				23d. Date of de	livon
P.O. Box 687 that the death certificated by the attending perfeached for use as	icial	in the past 12 months?		Ectopic pregnancy Other (specify)			Month Month	Day Year
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ds, quire: en sig	ted	<u> </u>	- W		()	1 🗌 Yes	2 → No 3 □ P	robably 4 🗌 Unknown
e law re has be ge 2 shd	를					24a. Was an autopsy	prior to	topsy findings available completion of cause of
<b>Re</b> The I	5					performed		s 2 🗆 No
of Vital Rec Physician: The lav r this certificate has	l &	25. Was case referred to medical examiner?			Death (Check onl	ly one)		
FVI Physical this call direction	2	1 Yes 2 No 1 Hospital: 1 27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatier of injury 28b. Time of				e 6 Other (Spec	sify)
ding th.	cate		oth, Day, Year) injury	28c. Injury at work? M 1 \sum Yes 2	- 1	. Describe how is	njury occurrea	
Sion Atten r dea sctor: by the	Certificate:	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farm, stre			Location (Street	t and Number or Ru	ral Route Number,
Division of Vital Records, tal or Attending Physician: The law requires rs after death.  I Director: After this certificate has been signed in by the funeral director, page 2 should b		build	ing, etc. (Specify)			City or Town, S	tate)	
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examinet: On the ba	pest of my knowledge, death of	occured at the time, date a	and place, and du	ue to the cause(s	s) and manner as sta	ated.
the Finit 24 the Finite	ĕ <b>¥</b>	only one) 3 L Certifying Nurse Practioner	To the best of my knowledge, o	leath occurred at the time,	date and place, ar	nd due to the cau	use(s) and manner as	stated.
5 with 50 00 00 00 00 00 00 00 00 00 00 00 00		29b. Signature and title of Pertifier	<b>t</b>	29c, License numb	JUT	29d.	Date signed (Mont)	
			<u> </u>	1041		, 1/4	10 rch 34	12010
15		30. Name and address of person who completed cau	se of death (Item 23a) (Type, P	rint) ave (	Colu	2919	Man	4
Sta	ate	31. Date filed (Month, Day, Year) 32. F	Registrar's Signature	1				
Regist		MAR 25 2010 Sevent	J. Marke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 4:00 P 2010 Clifford R. McIntee March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Paltimore

9. Birthplace (State or Foreign Country) Catonsville <u> Charlestown Care Center</u> 8. Date of Birth (Month, Day, Year)
Dec. 24,1915 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Months Hours Min. 1 √ M 2 □ F 94 Director 213-01-0360 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Medical Examinar must be notified at Director 1 □ Yes 2√2 No MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Lane Apt. 308 South

12. Was Decedent Ever in U.S. Armed Forces?

1 Styles 2 \subseteq No 1942 | 1 \subseteq Year or Dates: 1945 Funeral 709 Maiden Choice Lane 21228 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, The "Madia once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Body & Fender Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Clinton Patrick McIntee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Catonsville, MD. 21228 JoAnn Hahn /Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 3/23/2010 Lorriane Park Cem. Woodlawn, Maryland 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee allice <u> 1328 Sulphur Spring RD. Arbutus,MD.</u> 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, Usiesaes or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ending physician and use as the burial-transi Due to (or as a consequence of): Physician/Medical attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 Yes 2-No 1 ☐Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Box 68760 Division of Vital Records, or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

72 hours after

Baltimore, Maryland 21215-0036

4+1

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Demorte Md

10-02274

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Thomas Tavon Mil			tate o	f Maryland	/ Depar	tment of	Health	h and	Menta	al Hyg			201	0 0)10
	R	For State			Cen	ificate of	Deau			2.	Date of Dea	eg. No th		3. Time of Death
Physisian Medical Examine	r	. Decedent's Name (First, Midd		Thomas				ler			Month March 21		Year 10 4c. County of Dear	0058 hrs
	4	a. Facility Name (if not instituti		street and numbe	r)	4	b. City, To Baltim		ocation of	Death		ľ	4c. County of Bear	,
		2600 Blk McElderly S	6. Sex	7. A	ige (In yrs. la	st birthday)	If Unde		If Under	24Hrs.	3. Date of Bi	rth (Mi	M/DD/YYYY) 9. B	irthplace (State or
Funeral Director		215-94-3524		M 2 F	30		Months	Days	Hours	Min.	9-22	-1	979 Fore	ountry) MD
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after	<u>}</u>	3 Widowed 4 D  15. Decedent's Education (Sp		If Yes, Give Year or Dates:	ompleted)	46a Dagadan	te Henal	Occupation	on (Give ki	ind of wor	rk done	16t	b. Kind of Busines	
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5-0036 lled within 77 Hygiene. d other than the Medica		17. Father's Name (First, Midd	e, Last)					1			First, Middle, e Dav		en Surname)	
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Baltimore, pernit. Pages I ar Department of He Important: If ite	1	21. Signature of Funeral Servi		see (	`	22.1	Name and	Address	of Facility	Ma h A	rcn i	sas	Balto,	MD 21202
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Box 68760 e death certificate t the attending physical for use as the bh	sician/Me	23b. Was decedent pregnant i past 12 months?	1 the	1 Live birt	h ntattime of d		etal death other (Spe		EGOPIC	c pregnan	icy _		Mona	,
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tal Records, P.O. Box 68760 tian: The law requires that the death certificate the certificate the second signed by the attending physector, page 2 should be detached for use as the bu	by Phy	Part II. Other significant cor	ditions	contributing to c	leath but not	resulting in the	underlyin	ng cause (	given in Pa	art i.				Probably 4 Unknown
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ord aw req as bee	Completed											topsy	ed? deati	
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Division of Vital Records, tal or attending Physician: The law requirers after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should	. To	1 Yes 2 No 27. Manner of Death	1	28a. Date o	f Injury Day Year)	28b. Time o	f Injury		ıry at Worl	··· [6	28d. Descri	be hov	w injury occurred red in police re	elated incident
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the H thin 24 of the F mplete	Medical	(Check only one) 2 Medical	Examine	er: On the basis of and manner sta	examination	and/or investig	gation, in r	my opinio	n, death o	ccurreda	t the time, d	ale an	id place, and dde	(Month, Day, Year)
To with	Me	29b. Signature and title of ce	rtifier				2		.M.E.		ME	- 1	March 21, 20	
		Theodore	11,	Kind 7	Ry n	<u> </u>			.(VI. L.					
3		30. Name and address of pe Theodore M. King,			e of death (Ite nt Medical	_{em 23a)} I Examiner	111 9	Penn S	treet, B	altimore	e, MD 21	201		
	tate	31. Date filed (Month, Day, Y	ear)	32 Reg	gistrar's Signa	ature de								
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			or Print in Black I				•	
	-	For State Registrar	e of Maryland / De _l	ertificate of D		ental mygler Reg. N	2010	00152
		Negistrar  1. Decedent's Name (First, Middle, Last)			Julii	2. Date of Death		3. Time of Death
Physicia /Medic	_	Toye C.	Mc Fadde	n		Month, 2	Pay Year 2010	7:40 AM
Examin	_	4a. Facility Name (If not institution, give street ar	nd number)	4b. City, Town, or L		4	c. County of Dea	th
			spital	Baltimo	ore If Under 24 Hrs.		na	Shalana (Chata as Faraina
Funeral Director		5. Social Security Number 212-21-4052 6. Sex 1 ☐ M 2 €	7. Age (In yrs. last birthda 39 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea 1-14-19	r) _   Co	thplace (State or Foreign ountry) MD
		Usual Residence of Decedent						
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1 and Heall tem 2		20a. Method of Disposition	20b. Place of Dis	sposition (Name of	; D		Location - City or	
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mit. I partm porta y Inju		21. Signature of Funeral Service Licensee		22. Name and Address	of Facility	March Ea	ast F/H	
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		23a. Part 1. Ent at the disease, or complications shock, or heart failure. List only one cause	hat caused the death. Do not e on each line.	enter the mode of dying,	, such as cardiac o	r respiratory arrest,		Approximate Interval Between
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Attending Physician: The redeath. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?  1   Hospital:		Othor	26. Place of Death			
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r Atte er deg recto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e.	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Street City or Town, St		lural Route Number,
ital or ral Dil	Cer							
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Examiner: On	To the best of my knowledge, do the basis of examination and/o I manner stated.	eath occurred at the time r investigation, in my op	e, date and place, inion, death occurr	and due to the cause ed at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
o the vithin o the	Med	29b. Signature and fille of certifier	manner stated,	29c. License	number	29d.	Date signed (Mon	th, Day, Year)
F > F 0		Medral Ho	useofficer	19451	48	H	27h, 21	2010
2		36 Name are address of person who completed	cause of ath (Item 23a) (Typ		K.,		1117-	•
0	Ĉ ń	Cicardo Osurno 2000			more Mo	ryxand 2	1223	
Sta Registr		3h. Date filed (Month, Day, Year)	32. Registrar's Signature	del		H		
riegisti		MAR 25 2010 A	war b. In					

10-01968 Linda McNeill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1 Decedent's Name (First Middle Last) Physician/ 2. Date of Death Month **Medical Examiner** 1901 hrs Linda McNeill March 9, 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number UNK 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign Days Director Months Hours 54 Nov 29, 1955 1 M 2 X F Maryland Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits MD Baltimore Baltimore or items 23a or 28a-f show must be notified at once. 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at nare. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 903 W. Saratoga St; Apt 3 21202 IISA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White etc. 2 X No 1 Yes 4 Divorced If Yes, Give Year 3 Widowed Specify: black Yes 2 X No specify 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry UD Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 0 housekeeping 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Harold Dotson Catherine Spencer 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B Michael Dotson/brother 3004 Presbury St; Baltimore, Maryland 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town State crematory or other place) Burial 2 Cremation 3 Removal from State Baltimo
permit. Pages
Department of
Important: I Donation 5 X Other Specify in state 5 21. Signature of Funeral Se RONA ice Licensee State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval re. List only one cause on each line /Medical a. Narcotic Intoxication Death Immediat Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of); Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Division of Vital Records, P.O. Box 68760, Bospital or Attendiog Physiciae: The law requires that the death certificate be executed 24 hours after death. and Physician/Medical UNPENDED AMENDED attending physician or use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months 2 Pregnant at time of death 5 Other (Specify) s certificate has been signed by the atterector, page 2 should be detached for 1 1 Yes 2 ✓ No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other After this ၉ 1 Yes 2 No 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural unknown FOUND: Pending 1 Yes 2 ✔ No To the Funeral Director: completely filled in by the Mar 9, 2010 1800 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 3501 Garrison Boulevard Apartment 6, Baltimore, MD determined (Specify) Multi-Family Apt Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Sign ature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. March 17, 2010 me and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006** 

State

Registrar

32. Registrar's Si

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2829d Per Phy G901 3/25/2010 State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3/18/2010 nt's Name (First, Migdle, Last, Month **Physician** /Medical lity Name ( 4b. City/Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Date of Birth (Month, Day **Funeral** Min. Months Days Hours 1 M 2 1 3 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, fown of Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director ruidi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or items 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2. No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. ģ 3 ₩idowed 4 Divorced 72 hours than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Kind of Busine (Give kind of work done during most of working life DO NOT use retired) Elementary/Seochdary (0-12) College (1-4or 5+) d 2 should be filed with and Mental Hygien 7 is marked other the er's Name (First, Middle, Maiden Surgame) 19 Mo Fainer's Name (First, Middle, Last) Be ဂ Ony or Town, State, Zip Code) Department of Health an Important: If then 27 is not any Injury or other 19b. Mailing Address /Street and Nu r Rural Route-Number, 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, grematory or other 1 Burjat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dwing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and Due to (or as a consequence of): the burialattending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No The death? 1 ☐ Yes elo 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person tho completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 MAMONTH MARGARET LOUISE McCARDELL 21. 5:00 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A 1126 HEWITT WAY **Baltimore** Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Yes November 28 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Director 218-32-3988 Virginia 77 Yrs Usual Residence of Decedent or 28a-f shov permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Me Treal Examiner must be notified at once. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1126 Hewitt Way 21205 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 M No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Schifflett Flovd. **Allen** Shifflett Mildred. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn McCardell (Daughter) 1506 Pearl Avenue, Crofton, Maryland 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗷 Cremation 3 🗆 Removal from State Bayview Crematory March 23,2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Foneral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Baltimore, Maryland 21225 A art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one lause on each line. Interval Between mmediate Cause (Final sease or condition Onset and Death Physician/ cell Metastatic Squamous year Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Division of Vital Mecorus, .... resulting in death) Last Due to (or as a consequence of): physician a the burialby Physician/Medical ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year 1 Yes 2 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 🗷 Residence 6 🗌 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-XI Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) Michael R. a Medical Doctor March 23, Res - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21287

Registrar DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 19a-b, per INI g902 4/13/10 III. State of Maryland / Department of Health and Mental Hygiene 0 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20T0 David F Ne1ka 7:10A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8146 Harvest Court Anne Arundel Severn 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 8, 1945 1 🗓 M 2 🗆 F Months Davs Hours Min. 65 Director 216-42-1797 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21144 8146 Harvest Court U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72. It and Mental Hygiene. To is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Management Paper Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanley Nelka Catherine Mucha 19a Informants Name/Relationship (Type Print) Betty J. Nelka/ Wife Miss Christine Nelka /Sister 8146 Harvest Court, Severn, MD 21144 State, Zip Code)
19724 Selby Avenue Puolesville, MD 20827 permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 26, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2010 Glen Burnie, MD 21. Signature of Funeral Service Licenseg 22. Name and Address of Facility Singleton Funeral & Cremation OI Services PA 2nd Ave. SW Glen Burnie MD Approximate Interval Between Onset and Leath Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final Enysician Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine drany, reading to infine diate cause. Enter Underlying Cause (Disease or iinjury Duc to (or as a consequence of): burial-transit The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Yes 2 □ No 9 Unknown the detached 9 Unknown P.O. á signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No Completed 1 Yes 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{A}\) Residence 6 \(\sum \) Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 27. Manner of De nh 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 39505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Rumie, 21061 MD. 101

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month March 2010 T₈y Rosie Mae Porter 12:30P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2318 East Hoffman Street Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Min Maryland 1 □ M 2 🕱 F 217-26-4793 Director 88 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 K Yes 2 No Baltimore 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 2318 East Hoffman Street 21213 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☑ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 X Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natun traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>o</u> Bertha Hackett Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) portant; If item 27 is rinjury or other tran 2318 East Hoffman St., Baltimore, MD 21213 Ollie Lyles / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or oth ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 03/23/2010 Hanover, Maryland 4 3 Donation 5 Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licens MD 21076 7522 Connelley Dr., Ste. P, Hanover, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Alzhline disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 arphiPhysician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Cther (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death n signed by the a 1 ☐ Yes 2 p 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown been signated by should be 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy perform death? performed?

Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 XNo 1 🗌 Yes ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

Grank

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701 LOWSUN,

Charles

N.

32. Registrar's Signature

March 23, 2010

MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Raym	ond Prest		1- For State	State	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2010 9 5											
Medi	Physici cal Exami	an/	Registrar 1. Decedent's Name (First Raymond	, Middle,La		Prestri	dge, Jr.				- 1	Date of De Month March 21	ath Dav	Year		3. Time of Death 1736 hrs
man n			4a. Facility Name (if not in	stitution, g	ive street and nur	nber)		4b. City, Tow		ocation of D		IVIAI CIT Z I	4	tc. County of		
	Funeral		Baltimore Washi  5. Social Security Number				. last birthday)	Glen Bu		If Under 24	4Hrs.	8. Date of B		Anne Aru		hplace (State or
	Director	,	216-86-1792		X м 2_F	38	Yrs	Months	Days		Min.	09/27/			Foreig	
			Usual Residence of Dece	dent										l		
	ow any		10a. State 10b. C	- 1	1 ـ 1		ty, Town or Locat	ion								10d. Inside City Limits  1 Yes 2 No
	uryland Sa-f sh at once	Director	Maryland Ann 10e. Street and Number	e Arun	ger	Pas	adena	10f. Zip Co	ode	<del></del>			10g. Ci	itizen of Wha	t Cour	
1	the Ma a or 23 tiffed		7779 Outing Av	enue				21122						U.S.A.		
0	th with	Funeral	11. Marital Status 1 Never Married 2	Mossia	12. Was Dece			Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					No- 14. Race - American Indian, Black, White, etc.			can Indian, Black,
)	ter dear				1 Yes	2 X No	1	Yes 2X	,			, , , , ,		Specify:	Whi	te
n	3 Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)								16b.	Kind of Busi						
u	o 172 ho an "na cal Ex	ete	Elementary/Secondary	(0-12)	College (1-	4 or 5+)		ost of workin		O NOT use	retired	d)				
5.0036	withir giene.	Completed	17 Father's Name /First I	Aiddle Lac	N/A		Home 1	mproven		Mother's N	ame /E	iret Middle		onstruct	tion	· <u> </u>
7	FIGURE, IND. LIE 13-0030  Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Raymond G. Prestridge, Sr. Kathleen								Α.			tman			
Š	should and M and M 17 is m	٩	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  Kathleen A. Sullivan (Mother)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cook  214 Kenwood Road Pasadena, Maryland 21122									Zip Code)				
	E, IV  I and 2  Health  item 2  r traur	ı	20a. Method of Disposition	1			p. Place of Dispos crematory or otl	ition (Name				Date		Location - C	ity or	Fown, State
Š	Pages tent of tint: If	- 1	1 X Burial 2 Cre 4 Donation 5 Of	mation 3 her S <i>pecif</i> j		m State G1	en Haven M			03	3/26,	/10	G1	en Burn	ie,	Maryland
Baltimoro	permit. Pages 1 and 2 s Department of Health at Important: If item 27	١	21. Signature of Funeral S				MeC.	ame and Ad	dress o	f Facility ak rune	eral	Home,	P.A.			
	Physician	$\dashv$	23a. Part I. Inter the disea	ase, or com	plications that car	used the dea	320	4 Mount	ain	Road Pa	asade	ena, Ma	ryla	nd 2112		Approximate Interval
gh	/Medical Examiner		failufe. List only one Immediate Cause (Final d	isease a	Myocard:											Between Onset and Death
			or condition resulting in de Sequentially list condition:		Due to (or as a o	consequence	of):									
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6876	ifficate ng phy: as the b	J/Me	IF FEMALE: 23b. Was decedent pregna	nt in the	23c. If yes, or	utcome of pre	egnancy	al death	3	Ectopic pre		у	23	3d. Date of de Month	elivery D	ay Year
a you	atte	sician/Me	past 12 months?	Unknow		nt at time of o		ner (Specify)	)							
	hed the	F	Part II. Other significant	onditions			resulting in the u	nderlying car	use giv	en in Part I.		23e. Did t	obacco	use contribu	ite to t	ne cause of death?
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rde	law requi	Completed										24a. Was				opsy findings available impletion of cause of
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2	Steatosis of the liver    Steatosis of the liver   1   Yes 2   No 3   24a. Was an autopsy performed?   1   Yes 2   No 2   Yes 3   Yes 2   Yes 2   No 2   Yes 2   Yes 3   Yes 4   Yes 2   Yes 4   Yes 2   Yes 4   Yes 2   Yes 4   Yes 2   Yes 4   Yes 4															
	or Attend after death. Director: d in by the	Certification:	2 Accident 3 Suicide 6	Investigation	be 28e. Place	of Injury - At	home, farm, stree	t, factory, off	fice buil	ding, etc.	28	f. Location (		and Number	or Rur	al Route Number, City
2	E G Spi	Ser	4 Homicide 29a. Certifier	determine	(opec.iy)						$\perp$					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical	(Check only   Certify		er: On the basis of	examination	edge, death occur and/or investigat									
	To To Con	Mec	29b. Signature and title of	certifier	and manner sta	ited.		29c. Li	cense r	number			29d.	Date signed	(Mon	h, Day, Year)
			2-2		100			0	.C.M.	E.			Ma	rch 22, 20	10	
			30. Name and address of p		completed cause			Penn Str	eet F	altimore	MD	21201				
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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** рм 7:15 Robert W. Rankin March 2010 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harbor Hospital Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 218 42 4490 1 X M 2 T F 64 Director 07/07/1945 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 No Director Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 330 Orchard Avenue 21225 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death \( \)
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any Injury or other trainmatin when than "natural", or items 23a any Injury or other trainmatin when than "natural". by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔼 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Drywa11 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marvin B. Rankin Harriette A. Moyer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Rankin / wife 330 Orchard Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 03/25/2010 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Holy Cross Cemetery : 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 namuse Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease by complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Prostate Immediate Cause (Final **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to for as a consequence off-If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed sician and burial-transi Exami Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No al or Attend after death. 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54413 Mor. 22,2010 Muemp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. Hanover St. Baltimore MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar MAR 25 2010

DHMH 17 Rev 1/2001

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obin Lee Rogers		Sta	ate of Maryla	and / Depa	rtment of	Health	and	Menta	l Hyg	jiene	•	20	Band of	0 0916	
	Re	For State		Cer	tificate o	Death			- 12	Date of Dea	Reg. No.	2 0	3 1	3. Time of Death	
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Medical Examine		Robin Lee Roge  a. Facility Name (if not institution		ımber)		4b. City, Tow	vn, or Lo	cation of		IVIAICII 20		c. County of	f Death	1	
	4	215 Choptank Avenue				Cambri				Dorchester					
Funeral	5	·	6. Sex	7. Age (In yrs. la	ast birthday)	If Under		If Under		Foreign					
Director		497-72-4440	1 M 2 F	49	Yrs	Months 3.	Days	Hours	Min.	Aug 30	0, 1	960	Co	untryMichigan	
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with the Maryland ns 23a or 28a-f show be notified at once.	1 2	0e. Street and Number				10f. Zip C	ode				10g. Cit	. Citizen of What Country?			
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r death with , or items 23	1	1. Marital Status		cedent Ever in U.	.S. 13. W	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				cify Yes or N ican, etc.)	lo-	14. Race White		rican Indian, Black,	
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215 be filed and Hy rked o		Sidney Zoloman Segall   Ada Viola													
21: Duid b Duid b I Men mari	2 1	9a. Informant's Name/Relations				ng Address									
MD 12 sho th and 1 27 is	L	Ray Rogers/spe	ouse		Place of Dispo				iue;	Cambr				and 21613	
Te, l and l'Heal		20a. Method of Disposition  1 Burial 2 Cremation	n 3 Removal		crematory or o		or cem	etery,		Date	20c. Location - City or Town, State				
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Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once TO Be Completed by Filmeral Director	1	21. Signature of Funeral Survice	Sicensee Warde	Mirecton	r 22.	Name and A State	ddress ( Ana	of Facility Comy	Boa	rd; 65	55 W	. Bal	tim	ore Street	
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Examiner		Immedia - Cause (Final disease or condition resulting in death)	a. oxycod	one, clo	onazepa	m, des	sipr	amine	2)						
	-1	h h													
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Divi	Certification:	4 Homicide		m resid				_					-	Cambridge,	
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To the Hos within 24 h To the Fur completely	Medical		and manne	er stated.	I GIRGOI HIVESU			e number						Month, Day, Year)	
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	İ	After Bra	side, M	)			J.U.	· · · · · ·							
1		30. Name and address of person Melissa Brassell, MD		ause of death (Ite Medical Exam		Penn St	reet. E	Baltimor	e, MD	21201					
		31. Date filet/Monto Cay, 19		Registrar's Sign		-	1 -								
Sta Regist	ate rar	MAR ZO Z	no cea	we for	7										

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amend items 17,18 per fh g904 6-7-10 yt
State of Maryland Poepartment of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ March 2010 Regina Mary Rigney 5:15 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 121 Robin Hood Road Havre De Grace Harford 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours (Month, Day, Year) 09/12/1935 Director 220-22-5644 75 Marvland Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importanti if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Havre De Grace 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 121 Robin Hood Road 21078 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White Specify: Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ -Schnedes Schmedes Lillian Trought Trought 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet R. Hart / Daughter 121 Robin Hood Road, Havre De Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Anatamy Gifts Registry 4 Donation 5 Other (Specify) 03/23/2010 Hanover, Maryland 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician colon Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or imjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performe death? certificate 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 🗌 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) After this . Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? nours after death.

neral Director: Aft 1 Tes 2 🗌 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination arrover investigation, in the desired section of the basis of examination arrover investigation, in the desired section of the basis of examination arrover investigation, in the desired section of the des within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Venkata J. Parsa M.D., 602 S. Atwood Rd, Ste. 200, Bel Air, MD 21014

State Registrar 31. Date filed (Month, Day, Year)

		T = For State Registrar	State of	Maryland		artment of H		nd Me		iene	10	09162
		1. Decedent's Name (First, Middle,	Last)					2	. Date of Deat	h	.,	3. Time of Death
Physi /Med		Franco G. R.	ACHTELL.	$\mathcal{L}$					Month 3	24 2	2010	5:35 AM
Exam		4a. Facility Name (If not institution,				4b. City, Town, or	Location of	Death		4c. County		
		MERCY MEDIC	AL CEN	TER		BALTI						
Funera	_		5. Sex 7 1 ☐ M 2 ☐ F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day,		9. Birthp Cour	lace (State or Foreign
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rdea	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.Sces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Orig	in? (Speci	fy Yes or No-		ce - Americ	
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ING 21213-UU30 be filed within 72 hours after death with the Marylan tial Hygiene. Indicate than "natural", or ftems 23a or 28a-f show event, the Medical Examiner must be notified at		3 Widowed 4 Divorced	Year or Da	tes:	16a Decer	lent's Usual Occupa	ation			16b. Kind of B		
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rand Z lid be filed fental Hygi rked other tic event, til	Be	17. Father's Name (First, Middle, L.	ast)				18. Mother	's Name (I	First, Middle, N			
	2	Carmine Rach	telli						Maria	Rade		
Mar d 2 sho th and th sm traum		19a. Informant's Name/Relationshi			1	g Address (Street a						Code)
C = 14 F	-	Gian Rachtelli	(son)	Tanh Bi	1	Linwood	Avenu					
O 80 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		itate C	emetery, crer	sition (Name of natory or other plac	' i	Dat		20c. Location	•	
Dalting permit. Pag Department Important: I		4 □ Donation 5 □ Other (Sp. 21. Signators of Foregral Service L		Bayv		rematory						aryland
permit. Departi		3	$\Rightarrow$	2		Name and Address Addre						
18218		23a Part1. Enter the disease, or o	mplication that a	used the death							утан.	Approximate
Physicia	,	Immediate Vause (Final disease of condition	200								-	Interval Between Onset and Death
/Medica	1	resulting in death)	a	dder or as a consequ	ience of):	er						
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.U. BOX bd / bU, the death certificate be executed y the attending physician and ched for use as the burial-transit	dical E											
ifficate	edic		u									
BOX 60 leath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			75-4				23d. Da	ate of delive	ery
deat deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		rth 2 ☐ Fetal ant at time of de		Ectopic pregnancy Other (specify)				M	onth	Day Year
cords, F.C. w requires that the d been signed by the should be detached	Physician/Me	9 Unknown										
OrdS, F requires that een signed b nould be deta	by	Part II. Other significant condition	is contributing to dea	ath but not resu	Ilting in the ur	nderlying cause give	en in Part I.					he cause of death?
ecords, law requires t as been signe 2 should be c	eted								1 76	es 2 No	3 Prot	oably 4 Unknown
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		OF Western day and dist							1□ Yes	2 <b>X</b> No	1 Yes	2□ No
OF VITAI Physician: r this certifice ral director, p	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 🔀 No	Hospital:	patient 2 □ I	ER/Outpatien	t 3 DOA Othe	ar.		Check only on			
	n: To	27. Manner of Death	28a. Date o	f Injury	28b. Time of				e 5 🗆 Reside 8d. Describe ho			у)
Attending Part death. ector: After by the funeral	atio	1 Natural 5 Pending 2 Accident investiga	tion	n, Day Year)	Injury		Yes 2□N	10				
DIVISION I or Attending after death. I Director: After sin by the functions	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of building	of injury - At ho	me, farm, str	eet, factory, office		28	f. Location (St City or Town	reet and Num	ber or Rura	al Route Number,
Urs aff												
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physiclan: To the la xaminer: On the ba and mann	sis of examinal	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, an th occurred	nd due to the ca d at the time, d	ause(s) and m late and place	nanner as s , and due t	stated. o the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier				29c. License	e number		2	9d. Date signe	ed (Month,	Day, Year)
		ma Ton	Lie	ND		192224	67822	L		3-24-	10	
		30. Name and address of person w		of death (Item		Print)						
		DANIEL BOUTS!	KARIS	301 5	St. Par	ul Place	BA	Itim	ore M	0 21	202	-
S Regis	tate strar	31. Date filed (Month, Day, Year)	annua 32. Re	egistrar Signal	arke	cl Place						
		PROBLET OF LOID	1	/ //								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RUTTIN *lartha* 202 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwes Ranchillstown altima Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. March, Pro Year)1924 West Virginia 579-32-8693 86 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10c. City. Town or Location 10d, Inside City Limits Director 1 Yes 2 No Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA Funeral 15 Warren Park Drive; Apt B3 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. black 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Nidowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 bindery operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillie Washington George Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15 Warren Park Dr; Apt B3; Pikesville, MD 21208 Jaculyn Elsa Ruffin/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signatur or uperal Service lice Wade State Anatomy Board; 655 W. Baltimore Street ector Baltimore, Maryland 21201 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physiciani Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit requires that the death certificate be executed Cause (Disease or imjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Day Year 4 Pregnant at time of death 9 Unknown 1 Yes 2 I the a האיסי עווא כפתוווcate has been signed by י funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or American within 24 hours after death.

To the Funeral Director: After this certificate has the completed filled in by the funeral director, page 2 s autopsy death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ည 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

540101010Nt voad Candylistaun MDZ1133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(7416)

MAR 25 2010

31. Date filed (Month, Day, Year)

D8062650

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 2ďľo Physician/ 3:36 P Helen Dina Rhoads Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year)
Jan 8, 1921 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** Mary land 1 □ M 2 🗓 F 89 Director <u>213-22-0</u>931 Usual Residence of Deceden 23a or 28a-f show ist be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County within 72 hours after death with the Maryland Director College Park 1 Yes 2X No Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral should be filed within 72 hours area received and Mental Hygiene.
' is marked other than "natural", or items 23? 20740 USA 9014 Rhode Island Ave; Apt 401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married whiate Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates 3 ₩ Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) food service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mollie May Fugitt Ralph William Edwards permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8706 34th Ave; College Park, Maryland 20740 Richard M. Zook/son Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (\$pecify) 22. Name and Address of Facility Board; 655 W. Baltimore St. Maryland 21201 Raltimore. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling Approximate 23a. Part 1. Enter the disease, Interval Between Onset and Death Immediate Cause (Final disease or ondition resulting in ath) Priysician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a consequence of, Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Day Year Month Other (specify) Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 X No 3 Probably 4 Dunknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 2 🗌 No 1 Yes certificate Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Other: ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 27. Manner of Death 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending М Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 25 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 0659AM Debra J Rostek March 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Cent Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 F Days June 4, 1957 Months Hours Country) 212-76-5689 52 MD Director Usual Residence of Decedent Fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 326 Highland Drive 21061 Apt. T1 U.S.A. or items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status r than "natural", or iter the Medical Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Ves Give White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Customer Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important; If item 27 is marked o any injury or other traumatic eve once. Robert Rogers Jean Ione Havenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Steven Rostek/Husband 326 Highland Drive Apt. Tl Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) March 25, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Crematory Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Deex Medical Due to (or as a consequence of): كمسحميح Examiner Endocardin weed Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown mitral valve, atrial abulation, been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hypertension, end stage page 2 s this certificate 1 ☐ Yes 2 ☐ No Yes 2 X funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ျှ 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 1457510356 march 21,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOUTH Greene St Baltimore MD 21201

State Registrar

jennifer

31. Date filed (Month, Day, Year)

32. Registrar's Signature

22

MD

Guyther

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ZOO James E. Ricks MARCH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTMORE HOSPITAL GNE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours Days 1 → M 2 □ F Sep 28, 1946 No. Carolina 240-74-3883 63 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 □ No **Baltimore Baltimore City** Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 USA 628 Yale Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 🗌 No 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Company Security Officer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Seabreeze Not Known 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 628 Yale Avenue Baltimore, Maryland 21229 Mary Hope Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Catonsville, Maryland 03/23/10 4 ☐ Donation _5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signative of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 -UC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset,and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL hour ACUTE YPERTENSIVE CARDIOVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200 No 1 Tyes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 3 DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient

**Physician** * /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Exemitrer must be notified at

and Mental Hygiene.

Pages 1 end 2 should be finent of Health and Mental Int: If item 27 is marked o

: If item 27 or other t

permit. Page Department of Important: If any injury or once.

Director

Funeral

2

Completed

Be

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filed within 72 hours after death with the Maryland

21215-0036

Maryland

Baltimore,

/Medical

Examine and burial-trar physician Physician/Medical the as attending for use pe page 2 should Be Completed certificate funeral director, After this

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law requires that the death certificate be executed

P.O. Box 68760.

Records,

Vital

Division of

Hospital or Attending Physician:

death.

24 hours after deat Funeral Director: filled in by the

within 2

**mpletely** 

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CIRRHOTIC

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certification: To 4 Homicide Medical 29a. Certifier (Check only one)

27. Manner of Death

2 Accident

3 Suicide

1 Natural

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Day Can

5 ☐ Pending investigation

6 Could not be determined

29c. License number D 22648

Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) MARCH 17, 2010

and address of person who completed cause of death (Item 23a) (Type, Print) m.D. 900

28a. Date of Injury (Month, Day, Year)

32. Registrar's Signature

SOUTH CATION AVENUE BALTIMORE, MARYLAND

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MARCH 2010 **ELZELMA** ROBERSON 4:52 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 608 Maury Ave Prince Georges Oxon Hill 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Jan. 6, 1 □ M 2 🕱 F Months Days Hours Min. YT945 AL Director 422-62-8675 65 Usual Residence of Decedent if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Prince Georges Oxon Hill 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 608 Maury Ave. 20745 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Widowed 4 Divorced Black Year or Dates 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Surgical Technician Unitee Medical Center Be permit. Page 1 and 2 should be filled.
Department of Health and Mental Hy.
Important, If item 27 is marked any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willie C. Jones Rozener Likely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Jones - Daughter 608 Maury Ave. Oxon Hill, MD. 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem 3-30-2010 Suitland Md Signature of Euneral Service Licenses Marshall s Funeral Home of Maryland sclarin 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CANCER ON disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 6 MONTHS Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ig physician and as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Pregnant at time of death 9 Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆

within 24 hours after deat To the Funeral Director:

State Registrar

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TVAN AKSENTIJEUICH MO; 4060 Kenmore AW #1018 Alexandra, VG 22304

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 7:48 R Bernell Morris Smith 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fort Washington 7009 Calvin Court Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth  $J_{an}^{(Month,Day,Ye}$ Social Security Numbe 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours 1 XX 2 □ F "Î'931 Mississippi **Director** 79 427 48 1343 Usual Residence of Decedent 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director or 28a-f sl 1 Yes 2 No Fort Washington Maryland 10e. Street and Numbe Prince George 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o edical Ex miner must be Funeral United States 20744 7009 Calvin Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces' 1 Never Married 2XXMarried Black, White, etc. Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be flied within 72 of Health and Mental Hygiene. item 27 is marked other than "rother traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Mary Sanders Carl Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7009 Calvin Court, Fort Washington, MD 20744 Nancy Sinervo Smith (Wife) permit. Page 1 and 2 Department of Heath Important: If item 27 any injury or other tr once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Fort Lincoln Cemetery 3-26-2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Malignant Neoplasm Head, face, neck disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of al or Attending Physician: The law requires that the death certificate be executed safter death.

Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Pregnant at time of death 2 No detached 9 Unknown 9 Unknown as been signed by 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2X No prior to completion of cause of death? pade 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

9200 Basil Court, Ste 200, Largo, MD 20774

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Drivan Zama, M.D.

2010

31. Date filed (Month, Day, Year)

MAR 25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Stewart Larry Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** more NA If Under 1 Year I if Under 24 Hrs. 8. Date of Birth (Month, Day, Yea) 04 - 04 - 5 Birthplace (State or Foreign Country)
 MD 6. Sex '. Age (In yrs. last birthday) **Funeral** 1 🗓 M 2 🗆 F Hours 213-64-3865 55 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director X X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Division Street Apt."A" 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.African 1 Never Married 2 Married þ 1 ☐ Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed American permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Drafting Bechtel Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Wheatley Byrdell Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilton Street Baltimore, MD 21229 Larry Stewart, Jr.-Son 810 N. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 03-30-10 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 Gilmor Street Baltimore, MD23a. Part 1. Enter the disease, or compilerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 

Unknown Completed To the Hospital or Attending Physician: The law require within 42 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performec 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my called Medical 29a. Certifier

State Registrar

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

MAR 25

Robins Romer

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / State Registrar	Department of Health and N Certificate of Death	Ī	giene Reg. No 2 0 1 0	09170
	Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath Day Year	3. Time of Death
	Physici: /Medic		James Staton		March	21 2010	
	Examin	er	4a. Facility Name (If not institution, give street and number)  Harbor Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Deat	h
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Bir (Month, Da	N/A th 9. Birt	hplace (State or Foreign
	Funeral Director		220-14-1170 ^{1☑M 2□F} 86	Yrs. Months Days Hours Min.	12/01	/1923 N.C	arolina
	pu »		Usual Residence of Decedent				10d. Inside City Limits
	arylaı show	5		own or Location			1 ☐ Yes 2 XXNo
	the M 28a-f notifie	Director	MD Anne Arundel Seve	rna Park		10g. Citizen of What Co	
	with with the r		66 Simmons Lane	21146		U.S.A.	ay.
	death ms 2:	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Iha Medical Examiner must be notified at once.	ğ	Armed Forces?  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ ②Divorced  Armed Forces?  1 □ ③ ② Yes 2 □ No If Yes, Give Year or Dates:	1 ☐Yes 2點No Specify:	Hican, etc.)	Specify:	ack
5-0	72 ho 'natur	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of work	ing	16b. Kind of Business/	
121	within sne. than '	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	ire Chief (Retired)	`	FED Gover	nment
d 2	filed v Hygid Sther	ပိ	17. Father's Name (First, Middle, Last)		•	Maiden Surname)	mierc
<u>a</u> n	ld be lental ked c	To Be	James A. Staton	Gerlin	e Gowe	:11	
ary	shou and M s mar			9b. Mailing Address (Street and Number or Rui			Zip Code)
Σ	and 2 ealth in 27 i			66 Simmons Lane, Se			
ore	ges 1 t of H if item or oth		20a. Method of Disposition  1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place  Crem	etery, crematory or other place)	Date	20c. Location - City or	Town, State
Ë	t. Pag tmen tant; ijury					Crownsvil	<del></del>
- Bal	permi Depar Impol any ir once.		21. Signature of Funeral Service Licensee for home	23 Name and Address of Facility Joseph H. Brown 2140 N. Fulton	Jr. F Ave.,E	uneral Ho altimore,	me MD 21217
-	Physician		23 / art1. Firer the disease, or complications that caused the death. If shoc fire heart failure. List only one cruse on each line. Immediate Lause (Final disease or condition	A	or respiratory a	rrest,	Approximate Interval Between Onset and Death 5 hours
	/Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequent to the condition of the condition)	ce f):			1 week
	ped tis	iner	Sequentially list conditions, if any leading to him edials cause. Enter Underlying	ce of):			1
Ligh.	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequent)	to thrive			year
68760,	ificate be executed g physician and is the burial-transit	ial E		ancer			10 years
687	- m	edical	U				
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director; After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	ath 3 ☐ Ectopic pregnancy		23d. Date of de Month	livery Day Year
О.	at the I by th	hys	9 Unknown		00 811		
rds,	quires then signed and be de	Completed by	Part II. Other significant conditions contributing to death but not resulting the n+i q	g in the underlying cause given in Part I.	23e. Did 1	obacco use contribute to Yes 2 No 3 P	robably 4 Unknown
ecc	law re las be	plet	Hypertension		24a. Was	an 24b. Were a	utopsy findings available completion of cause of
<u>~</u>	: The cate t	Con	Diabetes			rmed? _   death?	2 □No
Zits	lcian certifi ector,	Be	25. Was case referred to medical examiner?	26. Place of Deat			
of	Phys r this ral dir	٦.	1 1 Tes 2 Dans 1 1 Inpatient 2 ER			dence 6 Other (Spe	ecify)
on	nding th. : Afte : fune	tion	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	b. Time of Injury 28c. Injury at Work?  M 1 Yes 2 No	200. Besonbe	non injury occurred	
Divisi	or Atter after dea Director in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home building, etc. (Specify)	, farm, street, factory, office	28f. Location ( City or To	Street and Number or R wn, State)	ural Route Number,
	Hospita 24 hours Funeral stely filled	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.				
	orthe omple	Med	29b. Signature and title of certifier /	29c. License number		29d. Date signed (Mon.	th, Day, Year)
	C>F0		Pil On, la H	D RESOOI		March 21	, 2010
	6+1		30. Name and address of person who completed cause of death (Item 23	ia) (Type, Print) 3001 South Hangua	e stree		1
	Sta	_	21 Date filed (Month Day Veer) 22 Perietrer's Signature			1-11-11-11-11-11-11-11-11-11-11-11-11-1	
	Registr	ar	MAR 25 2010 Cenera J. Ja				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:40 PM Agnes V. Schmidt 2010 Medical March **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death North Arundel Rehab Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Month, Day, Year, 9,1926 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) 1 🗆 M 2 👿 F Days Director **212-22-229**8 83 Yrs Usual Residence of Decedent items 23a or 28a-f show her must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD. 1 √2 Yes 2 □ No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6642 Whitmore Court Apt.171 United States 21061 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Completed Specify: White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) N/A Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Joseph Wingate</u> Ella Punte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3315 92nd Ave. East, Parrish, FL, 34219 Charles T. Deitzel/Nephew 2ua, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Loudon Park Cem. 3/25/2010 Baltimore, Maryland 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. . Signature of Funeral Service Licensee Sulphur Spring RD. Arbutus MD. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_{sician/} disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, eral Director; After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No. 1 Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-40521 Morch 18, 2010 DRIVE 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 MOSPITAL DR OCHANEY

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

NEW BORNIE, MD 21061

10-02281 Fric Sellman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ziic Seiiman		For State Certificate of Department of The Certificate of The Certi			2 U I L g. No.	09172
Physician	/	egistrar . Decedent's Name (First, Middle,Last)		2. Date of Death Month 21	n Day Year	3. Time of Death 1105 hrs
Medical Examine		Eric Michael Sellman  ia. Facility Name (if not institution, give street and number)  4b. C	ity, Town, or Location of Deat	March <del>20</del> ,	4c. County of Death	11001113
		St. Agnes Hospital Ba	altimore			N/A
Funeral Director	L	213-17-3540 1 NM 2 F 30 Yrs.	Under 1 Year If Under 24Hi onths Days Hours Mi		MM/DD/YYYY) 9. Birt LO, 1980 Cou	
w any			City			10d. Inside City Limits 1 X Yes 2 No
ryland a-f sho f once	3		. Zip Code	10	g. Citizen of What Cour	
th the Maryland the Maryland to 28a-f shootified at once		403 143rd Street, Unit #4	21842		United St	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Inportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Re Completed by Finneral Director	Jalin	1 Never Married 2 Married Armed Forces? If Yes, s	cedent of Hispanic Origin? ( 5		White, etc.	White
ural",	⋧┞	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's U:	2 No specify: sual Occupation (Give kind of		Specify: 16b. Kind of Business/li	
5-0036 ed within 72 hour sygiene. other than "natu the Medical Exan		Elementary/Secondary (0-12) College (1-4 or 5+) during most or Labo	f working life. DO NOT use re rer	tired)	Waterproo	fing
d within giene.	<u> </u>	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, M	laiden Surname)	
215 be files mal Hy rrked of	ů O	Walter C. Sellman, Jr.		y Kathle		
AD 21 2 should 27 is ma matic ev	2		ress (Street and Number or th Street, Ap			
ore, Nes 1 and of Health If item her trau		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition crematory or other place.	lace)	Date	20c. Location - City or	
ltime it. Pag urment ortant: ry or of		Atlantic Cr 21. Signature of Funeral Service Licensee	,		Glen Burn unera om	
Ba perm Depa Imp	1	132	8 Sulphur Spr	_		
Physician /Medical	1	23a. Part I. Enter the disease, or complications that caused the death. To not enter the me failure. List only one cause on each line.		or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Narcotic (morphine) in Due to (or as a consequence of):	toxication			
9		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				
nsit ted	Exal Exal	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.				
e execucian and cian and inial - tra		X UNPENDED X AMENDED 2,23a,27,28a-f,per	mE. g901 3/30	/10 TT		
3760 ificate b ig physi s the bu		3b. Was decedent pregnant in the			23d. Date of delivery Month	Day Year
Division of Vital Records, P.O. Box 68760, real or Attending Physician: The law requires that the death certificate be executed are after decreash. The this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit	ysicia	past 12 months?	(Specify)			
ing Physician: The law requires that the d After this certificate has been signed by the tuneral director, page 2 should be detached	~	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did to	bacco use contribute to 2 ✓ No 3 Prob	
v require	ompieted			24a. Was a autops	sy prior to d	topsy findings available completion of cause of
Reco	E			perform 1 Yes 2		s 2 No
ital sician:	8	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 FR/Outpatient 3	26 Place of Death (Chec		Residence 6 Other	
n of Vital   Iding Physician: h. After this certif		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe h	now injury occurred	
Sion Attend r death. ector: by the f	catic	Natural Accident  Natural Natu		unk	treet and Number or Ru	ral Route Number, City
Divi	Certification:	Suicide Science determined (Specify) found in house		or Town, Si Baltimo	treet and Number of Ru tate) 3231 Stra re, MD	ckland Ave
	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a cone)  2 Medical Examiner: On the basis of examination and/or investigation,	at the time, date and place, and in my opinion, death occurred	nd due to the cause I at the time, date a	e(s) and manner as state and place, and due to th	ed. e cause(s)
T S S	ğ	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo.	nth, Day, Year)
		N_M _ m	O.C.M.E.		March 22, 2010	
$\emptyset$		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Donna M. Vincenti, MD Assistant Medical Examiner 111 Pe</li> </ol>	nn Street, Baltimore,	MD 21201		
Staf	te	31, Date filed (Month, Day, Year)  MAR 2 5 2010  Annual 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Gwen 2. Date of Death Stone 3. Time of Death Physician/ Month Year 04:50P M 2010 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2914 WINTER CHASE WAY ANNAPOLIS ANNE ARUNDEL Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Country) 0470971918 Director 081-10-7906 NY 91 Usual Residence of Decedent or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No MD ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be "natural", or items 23a o Funeral within 72 hours after death with 2914 WINTER CHASE WAY 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black. White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🖁 No Baltimore, Maryland 21215-0036 Specify: 3 X Widowed 4 □ Divorced WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hour Dopartment of Health and Mental Hyglene. Important. If item 27 is marked other than "naturaly injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT **MEDICAL** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HARRIS GOLDSTEIN anna UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN KALLINS / DAUGHTER 2914 WINTER CHASE WAY, ANNAPOLIS, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 03/21/2010 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialthe attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: asn yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? ρ Month Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Tes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy erform this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's S

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death Month 13 Day 1. Decedent's Name (First, Middle, Last) Year **Physician** 2010 22:40 March 14, /Medical Ronald Swann 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Fort Washington Fort Washington Hospital 9. Birthplace (State or Foreign Country)
DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Voor 12 M 2 □ F Yrs Director 579-46-9513 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene.

* is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the in dicol Examinar must be notified at 1 XYes 2 □ No Director Prince George's Oxon Hill MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20745 Funeral 5116 Boulder Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Yes 2 ⅓☐
If Yes, Give
Year or Dates: 1 Never Married 2 3 Married 2XX10 aftimore, Maryland 21215-0036 1 □Yes 2XCNo Specify: Specify: \$ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department of Navy 4 yrs <u>Structual Engineer</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Marie E. Griffin William F. Swann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important; If item 27 is any Injury or other trau once. 20745 Oxon Hill, Maryland 5116 Boulder Drive <u>Marsha P. Swann/Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Olivet Cemetery 3/24/2010 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC Mt: 22. Name and Address of Facility Marshalls Funeral Home of Maryland 21. Signature of Tuneral Service Licensee Suitland, Maryland 20746 4308 Suitland Rd Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, Examiner ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 D Unknown 9 Unknown icate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably ◆☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? examiner? 1 ☐ Yes 2 ☐ Ho Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Matural 2 Accident Injury 5 | Pending death. 1 ☐ Yes 2 ☐ No hours after death. investigation the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ determined 4 ☐ Homicide within 24 hours a To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 2 1170/ Wype, Print)
Registrar's Signature ause of death (Item 23a) (Type, Print) 30. Name and addru State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ G. Shepperd Robert 2010 10:40 a^M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Timonium Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** March 22 1 X M 2 🗆 F 81 Maryland **Director** 220-24-5965 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Harford Jarrettsville 10e Street and Number 10g. Citizen of What Country? Funeral 21084 USA 1602 Jarrettsville Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ģ 1 Never Married 2 Married 10:40~P.M. Baltimore, Maryland 21215-0036 Yes 2 X No Yes, Give 1 ☐ Yes 2 🔀 No Specify Completed 3 € Widowed 4 □ Divorced White Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Balt. Co. Police Dept. 12 Vehicle Maintinence Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Shepperd Gladys Gaines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 Jarrettsville Rd. Jarrettsville, Md. 21084 Mrs. Cindy Heaps/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Co. 13-25-10 Towson, Md. Signature of Frineral Service Licen 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Division of Vifal Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Robert Shepperd March 22, 2010 Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) 2010 address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

JACKIE JONES

MAR 25

TIMONIUM,

2300 DULANEY VALLEY ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ March 24 1:20 A M Daniel Shannon Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Blakehurst Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) 1 XM 2 □ F Days Hours Yrs Director 88 220-05-2870 <u>Maryland</u> 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director must be notified 1 Yes 2 X No Marvland | Baltimore Towson ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21204 U.S.A. 1055 W. Joppa Road, #743 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give 1942 – 1945 Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ь 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", 3 🔽 Widowed 4 🗆 Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Telephone Company Engineer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Shannon Shanahan John Marv J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra once. 8820 Walther Blvd. #4108 Parkville, Maryland Rose T. McCauley Sister 20b. Place of Disposition (Name of Cemeter), crematory or other place)
Dulaney Valley
Memorial Garden 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-29-2010 Timonium Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Maryland 21204 1050 York Road Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Onset and Death Physician/ emplication OF disease or condition resulting in death) NIP enthis Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to for as a consuluence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director. After this certificate has been signed by the attending physician and
eled filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by car dianyopatr Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2 X No 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔲 Naturai injury 5 Pending FAI 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide December 23 209 1250 AM Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1050 W. JOPPA RUM, TOWSON MY Facility NVrsmy Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8303 MARZCH 24

Registrar DHMH 17 Rev 7/2009

State

Charles St

TOWSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HALLES

MONA

31. Date filed (Month, Day, Year)

M

32. Registrar's Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JR. WADE SHIELDS 10:3BM MARCH 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DEMING DR SUITLAND Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) Country) NORTH **X**□ M 2 □ F Months Hours Min Director 238 - 70 - 4117 CAROLIN Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director PRINCE GEORGE' 1 Yes 2 □ No MD SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 20746 UNITED STATES 3708 DEMING DR. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify. Specify:BLACK Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER PRIVATE permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RUBY RHODES WADE SHIELDS SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3708 DEMING DR., SUITLAND, MD VIRGINIA SHIELDS/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State HARMONY MEMORIAL 3/26/10 LANDOVER, MD 4 Donation 5 Other (Specify) 21. Signatura of Funeral Service Licens 22. Name and Address of Facility CAPITOL MORTUARY WASHINGTON MARYLAND NE 23a. Part 1. Enter the disea or complications that caused the deat Approximate Interval Between Onset and Death shock, or heart failure L Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that the death certificate be executed that initiated events resulting in death) Last -trar attending physician of for use as the burial Physician/Medical Box 68760 IF FEMALE s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? After this certificate 2 No 1 🗌 Yes Yes Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c} \begin{array}{c} \begin{array} \begin{array}{c} \begin{array}{c} \begin{array}{c} \begin{ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 📕 Natural 5 Pending 1 Yes 2 🗆 No death. 2 Accident
3 Suicide Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by after City or Town, State) fo the within 24 hours
the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Mary		artment of H			giene Reg. No. 20	0 09178
		Decedent's Name (First, Middle, Last,	)				2. Date of De		3. Time of Death
Physicia		NITNIA	SPENCE	D			Month MARCH		(ear 10 11:09 a _M
Medic Examin		NINA J.  4a. Facility Name (if not institution, give s		<u> </u>	4b. City, Town, or	Location of Death		4c. County of	
Examin	er	Tall a dillig (Tall a line)	a doc and manner,		,		ı	1	
_		PRINCE GEORGE S H		TER yrs. last birthday)	CHEV If Under 1 Year	ERLY If Under 24 Hrs.	8. Date of Bir		E GEORGE®S  9. Birthplace (State or Foreign
Funeral Director		1	TM 2 DE		Months Days	Hours Min.		4, 1935	Country) Virginia
Director		224-46-7345 Usual Residence of Decedent		75 Yrs.			Feb. 2	4, 1935	Virginia
nd <b>how</b>	=	10a. State 10b. County	100	c. City, Town or Loc	cation				10d. Inside City Limits
ırylaı I-f si	ct	D.C.			Washingto	n			1 <b>X</b> Yes 2 □ No
e Ma r 28¢ notif	Director					11			
h the	al	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	
h wii ns 2 nusi	Funeral	4006 Ames St.,				019			States
deat iten ner i		Tr. Marian Otatao	12. Was Decedent Ever i Armed Forces?	in U.S. 13. V	Vas Decedent of His f Yes, specify Cuban	panic Origin? (Sp , Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race -	American Indian, White, etc.
amilian S	ð	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		☐ Yes 2 🕱 No			Specify:	
urs a	Completed	3 Widowed 4 Divorced	Year or Dates.					ореслу.	Black
2 ho 2	ble	15. Decedent's Ed (Specify only highest grad		(Give I	lent's Usual Occupa kind of work done du	tion uring most of wor	king	16b. Kind of Busin	ness Industry
Than than than the Me	E O	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. Do	O NOT use retired)			-	
t bert		12			Clerk Ty	pist		Gove	rnment
land 27275-0036  be filed within 72 hours after death with the Maryland ental hyglene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at.	o Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
d be dent Ment arke	욘	James R. Car	mpbe11			Ma	rtha Ho	11and	
<b>Saltimore, Maryland 21213-0036</b> bermit. Page 1 and 2 should be filed within 72 hours affer Department of Health and Mental Hyglene.  mportant: If item 27 is marked other than "natural", o may injury or other traumatic event, the Medical Exam  nnce.		19a. Informant's Name/Relationship (Type	ne, Print)	19b. Mailin	ig Address (Street a	nd Number or Ru	ral Route Numbe	r, City or Town, Stat	te, Zip Code)
N 12 s alth a lath a la		Demeris Spencer /	Daughter	4006	Ames St.	N.E.	Wash., I	DC 20019	
Te, THE HE othe		20a. Method of Disposition	2	0b. Place of Dispo	sition (Name of	- !	Date	20c. Location - Ci	
no arto rt: If		1 Burial 2 Toremation 3 1	Removal from State		natory or other place ce Cremate		4/10	Bol+cu	ille, Md.
Itin		4 Donation 5 Other (Specify, 21. Sign ture of Funeral Service of nse							
Baltimore, Marylan permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Sign the V Fulleral Service Torrise	huor Ja	lley 14	. Name and Address	and Ave.	pitol Mo	ortuary, Mash.,	Inc. DC 20002
		23a. Part 1. Enter the disease, or compleshock, or heart failure. I st only on	ications that caused the	death. Do not ente	er the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
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Medical		disease or condition resulting in death)	Due to (or as a cor		AKKEST				
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11 /8 ts	Ē	cause. Enter Underlying Cause (Disease or iinjury							
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or Attending Physician: The law requires that the death certificate be executed direct death.  Or Attending Physician: The law requires that the death certificate be executed direct death.  In the fund the this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	dical E	resulting in death) East	_ DEMENT:	,					
ate b	ğ		d. DEFERME	18					
<b>68</b> // sertifica oding plase as t	Physician/Me	IF FEMALE:	3c. If yes, outcome of pr						
th ce	ian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 🗆	Fetal death 3	Ectopic pregnancy	,		23d. Date of Month	,
<b>box</b> death c the atter	sic	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time 9 ☐ Unknown	e of death 5 ∟	Other (specify)			Mortu	n Day Year
by the tach	Ph	9 🕍 Unknown							
that the	<u>8</u>	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
15, uires uld b	eq						1 🗆	Yes 2 No 3	Probably 4 🗷 Unknown
ord	Completed						24a. Was		re autopsy findings available
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DIVISION tal or Attendir rs after death. al Director: Af ed in by the fu	Certificate:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp		eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
Lalo rs af			3,(-,				ony or rom		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 XCertifying Physi	cian: To the best of my k	nowledge, death o	occured at the time,	date and place, a	and due to the ca	use(s) and manner a	as stated. the cause(s) and manner stated.
n 24 n 24 ne Fu	Mec		er: On the basis of examine Practioner: To the best						
To the withing the complete the		29b. Signature and title of certiler	1005	1	29c. License	number		29d. Date signed (A	Month, Day, Year)
		クナイカノ	(Y)	(1)	D 4626	56		13-19	7-2010
		30. Name and address of person who co	impleted cause of death	(Item 23a) (Time D	rint)			00 //	0010
		FITZGERAID BIRMING		. , , , , ,		EVERLY,	MD 207	785	
Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature 🗷	CHU				
Star Registra		MAR 25 2010	March A	bart	1				
		MAR & D CUIU	Marine 10	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MONTHROH SHIRLEY 21:58FM SANDLER Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** 1 🗆 M 2 💢 F Days Hours Min 0971671929 Director MD 218-28-6137 80 Usual Residence of Decedent or 28a-f show at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified it. 1 Tes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 SLADE AVENUE, #417 21208 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Nidowed 4 □ Divorced Specify: Completed Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) TEACHER College (1-4 2 5+) Elementary/Seconday (0-12) EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ **JOSEPH** SCHNITZER HANNAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s 4230 HARNESS DRIVE, HAMPSTEAD, MD 21074 STEPHANIE HARRIS / DAUGHTER or other Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State OHEB SHALOM MEM. PARK 03/24/2010 4 Donation 5 Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service Lice 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician ARRHYTHMIA Medical resulting in death) Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a sonsequence of): Cause (Disease or linjury PERIPHERAL ARTERIAL DISEASE and -tran that initiated events resulting in death) Last attending physician at for use as the burial-Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year signed by the a d be detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> BREAST Pivision of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate har performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 🗌 Yes ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 22, 2010 M.D. D38570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JEFFREY EDWARD

32. Registrar's S

7601

OSLER DRIVE

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STEPHEN MORGAN THOMPSON 2010 11:08 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIV OF MARYLLAND MEDICAL CENTER BALTIMORE BALTIMORE CIT 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F 102 09/06/1907 Maryland Director 216 05 4003 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medic a Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 U.S.A. 401 Folsom Street 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 6th Window Installer Webb Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Rebecca Lee Earnest Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Street, Maryland 21154 Karen Blades / granddaughter 3247 Forge Hill Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🖪 Burial 2 🗆 Cremation 3 🗀 Removal from State Elkridge, Maryland Meadowridge Mem. Park 03/25/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 Ritchie Highway 23a. Lart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of sician and burial-transit Exami that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be the as t IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Į, Dav 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been signated by page 2 should b 2 1 No 3 Probably 4 Unknown Completed 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death?
1 Yes 2 No perform within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page the Hospital or Attending Physician: 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5  $\square$  Pending injury work? 2 🗌 No Investigation 6 Could not be 2 Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and oue to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse. Practional: The basis of my knowledge and occurred at the time, date and place and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 42 102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 10-02285 William Turner Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

······a···	rumer		1- For State	tate of Maryland		rtificate of		na mentan		eg. No. 201	0 0918
	Physici	an/	Registrar  1. Decedent's Name (First, Midd	lle,Last)	·				2. Date of Deal	th	3. Time of Death
dedica	al Exam	iner	William Jose 4a. Facility Name (if not institution	ph Turner	)	1,	th City Town	or Location of Dea	Month March 21,	2010 4c. County of De	1609 hrs
			Union Memorial Hosp	. •	,		Baltimore	or Education of Boo	To County of Bo		
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. I	ast birthday)	If Under 1 Ye			th(MM/DD/YYYY) 9. I	Birthplace (State or
	Director		212-58-3320	1XM 2F	6	1 Yrs.		ays Hours M	ⁿ 12/07/1	1948	Country) MD
	any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locati	on				10d. Inside City Limits
	* ×	'n	MD		Ba]	ltimore					1 X Yes 2 No
	Maryland 28a-f show d at once.	Director	10e. Street and Number	* **			10f. Zip Code		10	0g. Citizen of What Co	ountry?
	led within 72 hours after death with the Maryland Hygener Hydener Hoter than "natural", or items 53a or 28a-f sho ther than "natural", or items 5a notified at once.		2608 Hunting				2121			USA	
	ath wit items 2	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Decedent Armed Forces	?			Hispanic Origin? (: an, Mexican, Puer		- 14. Race - Am White, etc.	erican Indian, Black,
	25			vorced If Yes 2	X No	1	Yes 2K	No specify:		Specify:	White
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36	in 72 t han "r lical E	ompleted	Elementary/Secondary (0-12)	College (1-4 or	5+)						
21215-0036	iled within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	Com	17. Father's Name (First, Middle	, Last)		חד	sabled	18.Mother's Nan	ne (First, Middle, N	Maiden Surname)	
215		Be	William Turner	:, Sr.					et Tambe		
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Baltimore, MD	permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is m injury or other traumatic		Daniel Cook/Ne 20a. Method of Disposition	<u>'</u>		Place of Disposi	tion (Name of c		ue, Balt Date	imore, MD 20c. Location - City	ZIZII or Town, State
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		y e	50 B()	Ŋ						. N., Hanov	
	nysician Medical	3 0	23a. Part I. Enter the disease, or failure. List only one cause	on each line.	tne death	. Do not enter th	ie mode of dyin	g, such as cardiac	or respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death
E	caminer		Immediate Cause (Final disease or condition resulting in death)	a. Hanging  Due to (or as a conse	equence o	of):					- Boatin
			Sequentially list conditions,	b							
		ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence o	f):					
3.	ed Isit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence o	f):					
	ate be executed hysician and e burial - transit	call	UNPENDED	d							
,09	ate be ohysici ne buri	Medical	IF FEMALE:	23c. If yes, outcor	me of preg	nancy				23d. Date of delive	ery
687	leath certificat e attending ph for use as the	ician/I	23b. Was decedent pregnant in the past 12 months?	he 1 Live birth  1 Pregnant at	time of de	oth		Ectopic pregr	nancy	Month	Day Year
Box 687	e death the atte	Physic	1 Yes 2 No 9 Un	known 9 Unknown		oth	ner (Specify)			1	
o.	hat the ed by t letache	by Pt	Part II. Other significant condit	tions contributing to death	h but not re	esulting in the u	nderlying cause	given in Part I.		bacco use contribute	-
S, P	requires that th been signed by hould be detach								24a. Was a		obably 4 Unknown
Sord	law requir has been 2 should	ompleted							autops perfor	sy prior to	completion of cause of
Rec	: The lav ificate ha r, page 2	O	25. Was case referred to medica				26 Pla	ce of Death (Check	1 Yes 2		Yes 2 No
of Vital Records,	hysician: The this certificate I director, page	o Be	examiner?		ent 2	ER/Outpatient		Other		Residence 6 Oth	er:
of)	ling Phy After th funeral		27. Manner of Death	28a. Date of Inju	ıry 'ear)	28b. Time of Ir	ijury 28c. In	jury at Work?	28d. Describe h Subject hang	ow injury occurred	
ion	or Attendi after death. Director:	atio	Natural 5 Pen-	stigation Mar 21, 2010		FOUND: 1536 hrs	1	Yes 2 V No			
Division	ipital or Att ours after do teral Direct filled in by	ertification	dete	ld not be 28e. Place of In (Specify) Ro		ome, farm, stree	t, factory, office	building, etc.	or Town, St		Rural Route Number, City
hand	Hospit 24 hour Funers cely fill	O	4 Homicide  29a. Certifier 1 Certifying P	hysician: To the best of m		ge, death occurr	ed at the time,	date and place, ar	1		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after decrear. To the Funeral Directorar. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Exa	miner: On the basis of examiner stated		-	on, in my opinio	on, death occurred		and place, and due to	the cause(s)
	. , , , ,	ž	29b. Signature and title of certific	er I				nse number		29d. Date signed (M	
	,		20 Name and address	who completed as well	le alle /ll-	020)	0.0	C.M.E.		March 22, 2010	
	7		30. Name and address of persor Ling Li, MD Assista	n who completed cause of d ant Medical Examine	•	Penn Stree	t, Baltimore	, MD 21201			
_	S		31. Date filed (Month, Day, Year)	32: Registra	r's Signat	· bar	Yest				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Day 20 Donald Francis Trinkaus 2010 2:46 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 5060 E. Eager Street Baltimore . Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Hours Min (Month, Day, Year) 09/01/1927 216-22-3946 Maryland Director 82 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 ▼ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5060 E. Eager Street 21205 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. em 27 is marked other thal Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Trinkaus Viola Farinholt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Marcus / Nephew 5060 E. Eager Street, Baltimore, MD 21205 injury or other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ott ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Anatomy Gifts Registry 4 ☑ Donation 5 ☐ Other (Specify) 03/24/2010 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service bicens e 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician de yew Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? ò Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ uld be Division of Vital Records, or Attending Physician; The law requires Completed 2 No 3 Probably 4 Unknown has beer page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Ves 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Fune

completed fil 29a. Certifier (Check To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#17perFH, G902,4/6/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Day Year Physician/ Christian 9:20PM Trust 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Forest Haven Nursing Home Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar • 20. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Months 1 X M 2 🗆 Maryland 217-05-3436 89 1920 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Baltimore Catonsville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 42 Pepperdine Circle 21228 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No 2-1943 Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Yes. Give ¾☐ Widowed 4 ☐ Divorced 11 - 1945Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Printer Printing should be filed with and Mental Hygien is marked other tf injury or other traumatic event, Be 17. Fether's Name (First, Middle, Last)
Gerard Trust 18. Mother's Name (First, Middle, Maiden Surname) ပ Amelia Schiedt permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Trust - Son 42 Pepperdine Circle, Catonsville, MD 21228 Saltimore, 20b. Place of Disposition (Name of MD TWesternamysr Chamlest ery @ Garrison Forest 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Denetion 5 Other (Specify) 4-2-2010 Owings Mills, MD Signature of Juneral Service 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition as cul Physician/ Medical resulting in death) Due to r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence or) burial-transit and Due to (or as a consequence of) attending physician Physician/Medical certificate be use as the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atter in the past 12 months? Month Day Pregnant at time of death 2 No Yes 9 Unknown 9 Unknown Division of Vital Records, P.O. Part <mark>II. Other significant₁conditions</mark> contributing to death∕but not <u>re</u>sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 prior to completion of cause of this certificate 2 2 No 1 Tyes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1.☐ Natural 2 ☐ Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) all A. A HME! 21 Ell

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 State 5HMand/Department Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician/ 19, 19:50p ^M 2010 March Threatt Medical Mamie 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's <u>Southern Maryland Hospital</u> Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth -30-1932 Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1 M 2 TxF Director 247-52-0227 78 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 X Yes 2 No Prince George's Capitol Heights 10e. Street and Number 10g. Citizen of What Country? Funeral 20743 USA 6901 Hastings Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: 3₺ Widowed 4 □ Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Prince George's County marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the N 8th Bus Driver Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Janie Gill Clarence McGriff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 2202 Manor Gate Terr. Upper Marlboro, MD Clarence E. Jenkins/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial Cem 3/26/2010 | Suitland, Maryland 22. Name and Address of Facility Marshall's Funeral Home of Maryland 21. Signature of Funeral Service Licensee 20746 4308 Suitland Rd Suitland, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ le ummia disease or condition resulting in death) Medical Due to ( Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 PInpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural Accident iniury 5 Pending death Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu To the within 2

Registrar

only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

11701

32. Registrar's Sig

Givingston Road Fort washington, maryland.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND PITEM#29a, perDVR, G901, 372572010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 355 A M I home 20 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner COPPER RIDGE YKESVILLE ARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🛱 F 219-22-9874 82 Director 6-11-1927 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 TYes 2 □ No Director MD. BALTIMORE OWINGS MILLS 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r Funeral 5000 HOLLINGTON 21117 USA death items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced 'natural". Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATION BALTO, CITY SCHOOLS other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental ဥ EVERETT B. BUTLER ADDIE MAE GRINAGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (f) Health a 5000 HOLLINGTON OWINGS MILLS, MARYLAND 21117 SHIRLEY B, WOOD(SISTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 3 Removal from State rema = 5 permit. Paginepartment Important: If any Injury or once. 4 ☐ Donation 5 □ Other (Specify) ARBUTUS MEMORIAL PARK 3-24-2010 BALTIMORE, MARYLAND QNATHAN D. HIBNER Name and Address of Facility 21. Signature of F REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence 4) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician ar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 KNo Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy 2 **X**Nn Division or Vital 1∐ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 ☐ Pending investigation Injury s fter dec. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours

To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical XNurse Practioner anner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 22,2010 R100599

State Registrar

MAR 25 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BONNE S. DANK, COPERRIDGE 71D Obrecht Rd, 54KESVITE, Maryland 21784

31. Date filed (Month, Day, Year)

32. Registar's Signature

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Denise Wilkerson 03 9 2010 48A /Medical 11: 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months 1 □ M 2 □ XF 219-40-5876 Director 03/04/1942 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 10a, State item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Exercites must be notified at Director 1 ☐ Yes 2X No Baltimore Co. Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1149 Granville 21207 Road U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ∐Yes 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify If Yes, Give Year or Dates: þ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th Grade Home Care Worker Self of Health and Mental Hygid Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Joseph David Gilliam ည <u>Martha P. Wilkerson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlo Moore(Niece) 1149 Granville Rd., Woodlawn, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot Joseph H. Brown F/H And Crematory 03/22/10 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home pane 2140 N. Fulton Ave., Baltimore, MD 21217 234. Part 1. En ir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate 2 use (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease on Irjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) I □Yes 2 □No P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death3 Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has certificate 1 ☐ Yes Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this After the 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. n 24 hours after death.

le Funeral Director: A
bletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29d. Date signed (Month, Day, Year) 29b, Signal ture and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

MAR 2 5 2010

Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Security 1. Secur

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physician/ Medical Examiner **Funeral** Director or 28a-f show should be filed within 72 hours after death with the Maryland must be notified at Director 23a Funeral items Examiner ō þ Baltimore, Maryland 21215-0036 "natural", Completed the Medical Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Be permit. Page 1 Department of Important: If it 5 injury Physician/ Medical Examine Examine Physician/Medical

State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Day 201^{rear} 6:15 ам Johnnie Clarence Williams 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Nursing Center 7. Age (In yrs. last birthday) Good Samaritan Balto If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 8-9-193 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours 061-56-7399 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Na Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6109 Eastern Parkway 21206 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ☐ Yes Yes, Give 2 XNo 1 Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic 9th grade Self Emploved 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Simons Williams Leona Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delia Black-Daughter 6404 Moyer Avenue Balto, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Oaklawn Cemetery 3-26-10 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Cell Lu Gancel Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be execute completed filled in by the funeral director, page 2 should be detached for use אף לאייבים אייבים בייבים בי that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day 4 Pregnant Pregnant at time of death Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy performe 1 Yes 2 No 2 4 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 4 No ည 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier **Localitying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 2 158570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3a) (Type, Print)
560/ Loch Ravon Wed Bolymine

DHMH 17 Rev 7/2009

State Registrar

Jerrance 31. Date filed (Month, Day, Year)

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Dorothy E. Wright 9:46 A M Medical March 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genesis Long Green Center Baltimore . Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Year, 215-12-5687 Months 87 Director June 9,1922 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director Examiner must be notified MD Baltimore Baltimore 1 Yes 2 XNo 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 6032 Hunt Ridge Road 21210 U.S.A. items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Force ò 1 Never Married 2 Married 1 Yes 2 No 72 hours after Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: White "natural", WW Widowed 4 Divorced Completed Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12th and Mental Hygie is marked other 17. Father's Name (First, Middle, Last)
Clarence Eicholtz Be 18. Mother's Name (First, Middle, Maiden Surname) 2 Clara Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shament of Health a tant: If item 27 is Sharma Wright (Daughter) 7624 E. Abory Ct. 20707 Laurel MD injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite 1 Xxurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/24/2010 Timonium, MD 22. Name and Address of Facility 3631 Falls Rd Balto, Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Franeral Service License MD 21211 any 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of) resulting in death) Last burial-t Physician/Medical death certificate be Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) ed by the a detached f q 🗌 Unknown 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE DISEASE Records, PULMONAMY 1 🗌 Yes Completed 2 No 3 Probably 4 Inknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 Yes 2 No Yes Division of Vital Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 - No ပု 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific D31136

State Registrar 9005 KUBRIDE RD., BALTIMORE, MD 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

amend segret or Printin Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State amend item 8 per fh g911 1-26-11 vt
Registrar Certificate of Death
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:15 PM William Harry Webster, Jr. 2010 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Forest Hill Rock Spring Village If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Man **Funeral** March Hours Min. Days **1XX**M 2 □ F Maryland 87 219-18-0385 Yrs. Director Usual Residence of Decedent fshow 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State notified at Director 1 X Yes 2 □ No 28a-f Maryland Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ral", or items 23a o Examiner must be Funeral with 23a 21001 USA 211 S. Rogers St. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1943—1946 Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 X Married Completed by within 72 hours after 21215-0036 1 🗌 Yes 2 🔀 No Specify. Specify:White "natural" 3 Widowed 4 Divorced ed other than "natur event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Civil Servant 0 Be Baltimore, Maryland Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental marked ည Frances Snodgrass Mary William Harry Webster, Sr. f Health and Menta item 27 is marked other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 S. Rogers St, Aberdeen, MD 21001 Teresa W. Smith / Daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ٥ Street, Maryland permit. Page Department of Important: If any injury or Emory Methodist Cem. March 29,2010 4 Donation 5 Other (Specify) Signature Tarring—Cargo Funeral Home, 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a n sequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year for Pregnant at time of death ed by the a detached f Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det 2 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 XNo prior to completion of cause of death? certificate 1 Yes 2 No 1 Yes ours after death.

eral Director, After this certific filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other Assist Living 2 [ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No M 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 🔀 certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 3/24/10 of death (Item 23a) (Type, Print) Parke Str. Suite 400 Aberdeen, MD Parke State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John McKee Allen 10:29 am March 03, 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth **Funeral** Country) Illinois 1 X M 2 🗆 F Hours June 04. Director 296-26-4953 76 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maryland Prince George's o 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 20904 3144 Gracefield Road, Unit #GVT-11 U.S.A. "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 X Yes 2 No 1952 - If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 X Divorced 1959 Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Claton Allen. Jr. Florence Etta McKee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent S. Allen - Son 13213 Locksley Lane, Silver Spring, MD 20904 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 03/08/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li ensi e Mo #1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphace, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Quise (Final Physician/ Respiratory Failure Medical resulting in death) Due to (or as a consequence of) Examiner Traumatic Brain Injury 30 Days Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consecuence of) physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation Records, 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an perform death? Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) 1 X Yes 2 ☐ No 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year, Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending □ Natural 6:00 pM 1 🗆 Yes 2 🗶 No X Accident 02/12/2010 Slipped in shower Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the Suicide
Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3144 Gracefield #GVT-11, Silver Spring, MD Rd. Home. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D 66066

Registrar
DHMH 17 Rev 7/2009

State

1029am

8600 Old Georgetown Rd., Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 08

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ М BETTY JO BRACMORT FEBRUARY 2010 1553 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY Social Security Number 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, 1 M 2 😾 Months Davs Hours Min **Director** 579-68-5658 58 1̃951 s.c. June Usual Residence of Decedent or 28a-f show 10b. County 10c. City. Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 ☐ No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 625 Chesapeake St., S.E. 20032 United States or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 "natural", If Yes, Give 1 ☐ Yes 2X No Specify Black 3 X Widowed 4 Divorced Specify Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th DOMESTIC DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ဥ Walter L. Nelson, Jr. Gladys Wadley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a If item 27 is <u>Jacinto Bracmort / Son</u> Staple St., NE#2 Wash., DC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State INCOLN MEMORIAL CEM 3/11/2010 4 Dpnation 5 Other (Specify) SUITLAND, MD 22. Name and Address of Facility Capitol Mortuary, Inc. 21. Signatur of Funeral Service Licens <u> 20</u>002 1425 Maryland Ave., NE Wash., DC or complications that daused the deaty Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disea Approximate shock, or heart failure nterval Between indione Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 for use as IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months
1 Yes 2 No Pregnant at time of death signed by the at I be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2X No Yes To the Hospital or Attending Physician: **Division of Vital** within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature MAR 1 1 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day} 2010 11:00 PM Margaret Peggy Jeanette Block March 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10110 Century Drive icott Howard 8. Date of Birth (Month, Day, Dec 31 9. Birthplace (State or Foreign Country)
Maryland . Social Security Number 7. Age (In yrs. last birthday, Year If Under 24 Hrs. **Funeral** Days 1 DM 2 DX Director 83 Dec 220-20-3019 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Ellicott City Howard 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral United States 21042 10110 Century Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. "natural", or 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home 11 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ and 2 should be Dagenhart Sigafoose Margaret E. Rodger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health are portant: If item 27 is injury or other trau George Howard Block, Jr. husband 10110 Century Drive Ellicott City, MD 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 3/10/2010 Woodbine, Maryland per nit.
Der artm
Importa
any inju 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 earnity ( Thomas M00957 23a. Part the Disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ RESPIRATEORY FAILURE disease or condition Medical resulting in death) Examiner PEURAL EFFIXION RILATERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ISCHEMIC FRDIOMYOPATHY Cause (Disease or linjury that initiated events resulting in death) Last burial-transit and attending physician for use as the burial Physician/Medical DISEASE ARTERY CORUNARY certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown cate has been signed by the atte page 2 should be detached for Month Year Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ EMENTIA Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) examiner? 2 **29**10 Other: 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မြ 28a. Date of injury (Month, Day, Year) funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

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ARTIK

3290 N.

0062704

Ridge Road

Swife

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PHYSICIAN

MD

Collect

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DETAI

29d. Date signed (Month, Day, Year)

104

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O 7 Samuel Bittinger 10:45 AM ÓЗ Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death stern Maryland Regional Medical Center Cumberland allegan 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 218-16-2780 1 🔀 M 2 🗆 F Months Days Hours Min. **Director** 83 1926 Usual Residence of Decedent or 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Directo MD Allegany Westernport 1 Yes 2 X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21562 20209 Paulton Road SW United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 white If Yes, Give 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Coal unknown Miner Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) 2 Henrietta L. Bowman Benjamin Harrison Bittinger Injury or other traumatic and 2 should be Health and Metem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24201 Pond Hill Road, Rawlings, Maryland 21557 David Bittinger/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Potomac Mem. Gardens 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Keyser, West Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 7 Wane 21562 111 Church St, Westernport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death ACUTE MYOCARDIAL INFARCTION disease or condition ONE HOUR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Medical tending pr., IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 L 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by STEWOSIS - SEVENE Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown DISLARE - SAVONE OBSTRUCTIVE PURNONANY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the autopsy perform Physician: The 2 🗆 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопрете 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) MARCH 8, DOU 337 (7 (MO) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

IRMET R MOEN

31. Date filed (Month, Day, Year)

Box 68760

of Vital

Division

32. Registrar's Signature

, MD 1068 NATIONAL INCHWAY LAVALE, MANTEND 21502

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Gloria 10:18 P M Louise Barnard March 7 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Nursing Home Frostburg Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 21 Birthplace (State or Foreign Country) 1931 West Virginia Months Days Hours Min. 1 □ M 2 🛣 F 78 234-46-6660 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Garrett MD Swanton 1 ☐ Yes 2/CXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15990 Maryland Highway 21561 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 20XNo 1 ☐ Yes 2 🔀 No white Specify: 3€Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Kasmier Viola Smiley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Henderson/daughter 15990 Maryland Highway, Swanton, Maryland 21561 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/11/10 Barnard-Henderson Cem. Swanton Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home No 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final HEART FAILURE CONGESTIVE disease or condition resulting in death) Due to (or as a consequence of): CORUNAMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was ar Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 ☐ No Other (Specify)

**Physician** /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed Funers after death. Funeral Directors After this certificate has been signed by the attending physician and stely filled in by the turnel director, page 2 should be detached for use as the burlat-transit

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Macical Examination in a filed and once.

Baltimore, Maryland 21215-0036

Examine Physician/Medical \$ Completed Be Certification: To 2

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

									1	□Yes 2 🔀	No 1	
5. Was case referre examiner?		7			26. Place of Death (Check only one)							
1 ☐ Yes 2 N	o	Hospital:	1 ☐ Inpatient 2	☐ ER/Outpatier	ıt 3 🗆	DOA C	Other: 4	4 Nursing Home		Residence	e 6 □Other	
7. Manner of Death			Date of Injury	28b. Time of		28c. In		1			niury occurred	
1 Natural	5 Pending		(Month, Day, Year)	) Injury							,,,	
2 Accident	investigation	1			М	1	□Yes	2 🗌 No				
3 ☐ Suicide	6 Could not be	9 00-	Disease of Indiana AA	have from the					000			

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29c. License number 026907

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) MARCH 08 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland, MD 21502

State Registrar

Medical

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31. Date filed (Month, Day, Year)

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within 24 hours a

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completely filled

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irene K. Brocenos March 9, 2010 12:50 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3126 Gracefield Road, BG 301 Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 D M 2XX F Hours Min. Nov. 7ay, Year 924 Massachusetts Director 027-14-7712 85 Yrs. Usual Residence of Decedent 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be 10g. Citizen of What Country? Funera 3126 Gracefield Road, BG 301 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White Completed 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Manager permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth, any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Peter Kaperonis Bessie Katenas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 9712 Evening Bird Lane, Laurel, MD 20723 John S. Brocenos/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 15 cemetery, crematory or other place Glenwood Cemetery 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 2010 Washington, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 MO1503 seph 1 004 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
2 mon th Immediate Cause (Final Pnysician/ Metastatic Esophageal Cancer disease or condition months Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence on ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 XNo 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\overleftarrow{\mathbf{X}}$  No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 XNo Other: 1 Tes ၉ 1 Inpatient 2 I ER/Outpatient 3 I DCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🕇 Natural iniury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 24 hours Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) ID March 9, 2010 D24093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mark Parkhurst, MD 3110 Gracefield Road, Silver Spring, MD 20904

State Registrar 31. Date filed (MAR 141) 2010

backet

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03/03/2010 М THOMAS W. COPELAND 2032 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 6. Sex 1 M 2 □ F Days Hours 0170371933 220-28-7468 77 **Director** Yrs. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No Rockville MDMontgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12708 Turkey Branch Parkway 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working

Materials Montgomery County id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Management Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ည permit. Page 1 and 2 should be to Department of Heatth and Ments Important: If item 27 is marked any injury or other traumatic etc. Annie R. Bright George T. Copeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 12708 Turkey Branch Parkway, Rockville, MD 20853 Laura Jane Copeland - wife 20a. Method of Disposition 20b. Place of Disposition (Name of emetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Mem. Park 3/12/10 Rockville, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signatur of Funeral Service Lio 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Emboli from aortic and iliac aneurysm Medical resulting in death) Due to (or as a consequence of) **Examiner** Aortic aneurysm Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Bilateral iliac aneurysm and the burial-tran Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death
Unknown signed by the a g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be the funeral director, 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending 2 Accident after death. 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 3/5/10 D66249 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Duran, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year State

DHMH 17 Rev 7/2009

Registrar

MAR 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day  $\mathbf{p}_{\mathsf{M}}$ Hazel S. Corriea 03 08 2010 12:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death <u>Shady Grove Adventist Hospital</u> Rockville Montgomery 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🗷 F Months Days Hours Min (Month, Day, Year) 02/21/1953 **Director** 579-80-8945 Trinidad Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 □ No Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 13032 Well Hose Court 20874 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1979þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No 1989 Completed 3 Widowed 4 Divorced Year or Dates. **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 In and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Security Officer Private Protection permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, is Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joseph Corriea Gladys Sharpe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shurland C. Corriea - Brother 719 Quincy Street, NW Washington, DC 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 03/20/2010 Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 3401 Bladensburg Road Brentwood, MD 23a. Part 1. In the the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death .Physician/ disease or condition resulting in death) Breast Cancer - Metastatic Medical Due to (or as a consequence of) Examiner Septic Arthritis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed End Stage Renal Disease, Hypertension, Diabetes 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? eral Director: After this certificate if filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 2 K No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending X Natural 5 Pending work? 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of pertifier

Jason M.

Prior,

9901 Medical Center Drive

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0069127

29d. Date signed (Month. Day, Year)

March 8, 2010

Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Esther Myrtle Cook 7:52 PM March 2010 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County **Examiner** emorie à If Under 24 Hrs If Under 1 Year 9. Birthplace (State or Foreign . Age (In yrs. last birthday 8. Date of Birth Funeral 1 □ M 2 🕱 F Days 0 4-0, 4-y, Year 10 Marvland 99 Director 220-01-5065 Usual Residence of Decedent show or 28a-f shov be notified at 10a. State 10c, City, Town or Location with the Maryland 10d, Inside City Limits Director Caroline 1 Yes 2 No Preston Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 21655 USA 7093 Laurel Grove Road "natural", or items 23 edical Examiner must death 1 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ timore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes Give Specify 3 X Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working home and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) some one else's 6 <u>Home maker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t and 2 should be fill f Health and Mental item 27 is marked of ည Charles Edgar Cephas Rosa Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 350 Misty Vale Dr., Middletown, De. 19709 Melvin Cook permit. Page 1 and 2 Department of Health Important: If Item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 3 Other (Specify) Ross Chapel Cem. 03-13-10 Preston, Maryland Signature Funeral Service Licenses 22. Name and Address of Facility Bennie Smith Funeral Home De.19904 St. Division Dover, W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Que to for es a consecuence of Cause (Disease or iinjury that initiated events as the burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ó Month 5 Other (specify) 9 Unknown 9 Unknown P.O. ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Nown Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? performed this certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 မှ 1 Impatient 2 - ER/Outpatient 3 - DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 🛎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 5 31. Date filed (Month, Day, Year) NAR 10 2010

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle | ast) 2. Date of Death 3. Time of Death Physician/ 05 Day Month 03 2010 ALFRED EARL CARDONE A M 8:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TALBOT 23824 MOUNT MISERY ROAD ST. MICHAELS Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 😿 M 2 🗆 F Months Days Hours (Month, Day, Year) Director 08/02/1935 NEW JERSEY 146-28-1524 28a-f show 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director TALBOT 1 Tyes 2 X No MD ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23824 MT. MISERY RD 21663 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Armed Forces; 1 Pyes 2 No If Hes, Give Year or Dates 1958—1960 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 hours after "natural", 1 ☐ Yes 2 😾 No Specify. 3 Widowed 4 Divorced Completed WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DIRECTOR OF PROCUREMENT FOOD SERVICE Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JOSEPH CARDONE DOROTHY EARL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN CARDONE/WIFE 23824 MOUNT MISERY RD., ST. MICHAELS, MD 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION CTR. 3/8/2016 STEVENSVILLE, MD Signature of Funeral Servide License 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the notice of the part as that or respirator area. Approximate Interval Between shock, or heart failure. List only one cause on each lin Inset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed -trar Due to (or as a consequence of): physician s the burial Physician/Medical ding p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? page death? 1 Yes 2 No Be

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires certificate To the Hospital or Attendinwithin 24 hours after death.
To the Funeral Director: Aft completed filled in by the fur

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Certificate:

Medical

25. Was case referred to medical examiner?		26. Place of Death (Check only one)								
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify)									
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		how injury occurred								
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	1 28e Place of Injury - At home form street i	factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
(Check 2 Medical Exam	rsician: To the best of my knowledge, death occu iner: On the basis of examination and/or investigati se Fractioner: To the best of my knowledge. Seeth	on, in my opinion, death occurred	at the time, date	and place, and due to the cause(s) and manner stated						
29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)						
> VM	MM	D39887		315/10						

21601

125 20+VA

DAVID H. SMITH, 8221 TEAL DRIVE, STE. 301, EASTON, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day March 2 0°1°0 8 2005 PM Marie A. Dresser 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Gilchrisi Hospice Center Social Security Number 6. Sex Baltimore If Under 1 Year 8. Date of Birth Month Day, Year, 05/01/1914 If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. Months Hours 1 □ M 2 🖫 F Massachusetts 015-20-3134 95 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ty∑Yes 2 □ No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 104 Parkway Avenue 21078 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Specify: White 1 □ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Secretarial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Ellen J. O'Shea</u> Lewis F. Dresser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie E. Sears (Niece) 1580 Salem Street, North Andover, Mass 01845 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) R.A. Ferris & Co., Inc 03/11/2010 West Chester, PA 22. Name and Address of Facility Zellman Funeral Home, P.A. Signature of Funeral Service Licenses 123 S. Washington St., Havre de Grace, MD 21078 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) racturelervica tebra Due to (or as a consequence of): Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on: Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? underlying cause given in Part I.

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 Is marked other transpring once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Completed by Funeral

Be

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MD

death with the Maryland

2002

March

Maryland 21215-0036

Baltimore,

Physician: The law requires that the death certificate be execuburial-trar physician attending p for use as t the page 2 should After

Division of Vital Records, P.O. Box 68760,

Hospital or Attending

after death.

within 24 hours a To the Funeral D

filled in by

completely

Medical

Physician/Medical ò Be Completed Certification: To

25. Was case referred to medical examiner?

5 Pending

Yes 2 □ No

27. Manner of Death

1 ☐ Natural

(Check only

Examine

1 □ Yes 2 No 9 □ Unknown	9 Unknown
	ns contributing to death but not resulting in the
encephalos	194h V
dehydratio	12
a Engara III	J V \

Hos

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 Yes 2 No 1 ☐ Yes

	26. Place of Death (Ch	heck only one)	
pital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	OOA Other: 4 \(\bar{\D}\) Nursing Home	5 ☐ Residence 6 XOther (Specify) # O	SPICE
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	Work?	Describe how injury occurred	-
Eprach 20,2010 MILLY MILLY	1 □Yes 2 No	tall	

2 Accident	investigation	Eprygry20,2010UNKnowVM	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)	ffi
29a. Certifier	1 Certifying Physi	cian: To the best of my knowledge, death occurred at	th

Location (Street and Number of Rural Route Number, City or Town, State) / 04 PG V WG Y AG H WOLL, MD 21078 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 💢 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(10)	and manner stated.	
29b. Signature and title of certifier	MD Dearty	29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deat (Item 23a) Type, Print) 0 32

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03/03/2010 ARNOLD EDWIN DRIVER 0112 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Hours Country) 0570771959 Director 217-74-7055 50 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No MD Montgomery Laytonsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 8617 Churchill Downs Road 20882 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Spirent Communications Regional Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Franklin Copeland Ethel Talley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Joya M. Driver - wife 8517 Churchill Downs Road, Laytonsville, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State cemetery, crematory or other
Gate of Heaven 1 XBurial 2 Cremation 3 Removal from State 3/10/10 Silver Spring 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the sease, or cour lications that caused the death shock, or heart foliume. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death MINUTES Immediate Cause (Final ^⁵Physician/ Acute myocardial infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death signed by the a Unknown g 🗌 Unknown P.0. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Asthma Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No 1 Yes 2 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 - Nodedired Other: ည 1 Inpatient 2X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

24 hours To the within 2

29b. Signature and title of certifier

Michael Kerr,

loche

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

BEAM

MD

Registrar DHMH 17 Rev 7/2009

State

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

3/3/10

29c. License numbe

D0050410

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

18101 Prince Philip Drive, Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILLIAM JOHN DENT MAR 12 2010 2:59 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2□ F Director 191-22-5863 88 Michigan 07/08/1921 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10a State 10b. County Director 1 ☐ Yes 2X No Maryland St. Mary's Lexington Park the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20653 45939 Rolling Road Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 72 hours after 1 X Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) General Store d 2 should be filed w th and Mental Hygiel 7 is marked other th 12 Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Thelma Dent Randell Byers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a David A. Dent/Son 45939 Rolling Road, Lexington Park, MD if item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 🖁 Burial 2 ☐ Cremation 3 ☐ Removal from State Department o important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Cem. 03/19/2010 Leonardtown, Maryland permit. 21. Signatur of Funeral School Licensee 22. Name and Address of Facility Brinsfield Funeral Home Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). that the death certificate be executed that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) o 9 Unknown ئە signed be Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>6</u> 1 ☐ Yes 2 🕏 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? The certificate 2 🗆 No Division of Vital 1 ☐ Yes 2 ☐ No 1 □ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Inpatient this Certification: To After this funeral d 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the pletely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MIX 0116022120 (VA) Mar 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER

bens

State Registrar

31. Date filed (Month, Day, Year) MAR 16 2010

TIDA KUMBALASIRI

LT MC USN

32. registrar's Signature

pares

BETHESDA MD 20889-5600

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amra 🖫	Collo		1- For State Registrar	Sie	ate of Marylan		ertificate of		anu	ivienta	пнуд		eg. No.	2010	09203	
I CALL	Physici	ian/ 1. Decedent's Name (First, Middle,Last) iner Tamara Eells  2. I												Year	3. Time of Death 0148 hrs	
equica	II EXAIIII	IIEI			n, give street and numb	er)	Γ.	4b. City. Tow	b. City, Town, or Location of Death					County of Dea		
			Prince Geor		. •	,		Cheverl					je's			
	Funeral		5. Social Security N	1		Age (In yrs.	last birthday)	If Under 1	Year Days	If Under 2	24Hrs. (	B. Date of Bir	th(MM/	(DD/YYYY) 9. B Fore	irthplace (State or ign	
L	Director		218-98-79		1 M 2 X F	29	Yrs		Days	Tiodis	IVAIII.	08/28/1980 Country) MD				
	any		Usual Residence of 10a. State	10b. County		10c, City	, Town or Locat	ion							10d. Inside City Limits	
	Maryland 28a-f show 1 at once.	5	MD	Prince	George's	Ну	attsvil:	le							1 Yes 2 X No	
,	with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Nur	nber				10f. Zip Co	de			10g. Citizen of What Country?				
1	ith the 23a or notifie		2404 57th	n Place	12. Was Deced	ent Ever in I	18 113 \\/	2078 as Decedent of		nia Origin	2/5000	if y Van ar Na	Uni	ited Sta	ates rican Indian, Black,	
	eath w items	Funeral	1 Never Marrie	ed 2 X Ma				es, specify C	uban, N	flexican, P	uerto Ric	can, etc.)		White, etc.	ricari indian, black,	
	after d	by Fi	3 Widowed	4 Divo	orced If Yes, Give Year or Dates:	2 K NO	1	Yes 2X	No s	specify:				Specify: W	nite	
	natur Exam	ted	15. Decedent's Ed		ify only highest grade		16a. Deceder during m	nt's Usual Occions of working					16b. F	Kind of Business	/Industry	
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2121	ild be f Mental narke event,	To Be	Harold Jo				I 19b Mailine	a Address (				ea Wr	_	t ity or Town, Stat	e Zin Code)	
MD 21215-0036	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygieral Department of Heath and Mental Hygieral Hungerial", or items 23a or 28a-f she Important. If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٦			e (Sister)		0.77								MD 20653	
<u>e</u> .	s l and f Healt ff item er tra		20a. Method of Disp		3 Removal from		Place of Dispos crematory or oti		of cemet	tery,	D	ate	20c. l	Location - City o	r Town, State	
Baltimore,	Page ment o tant: or oth		4 Donation 5	Other Sp	ecify:		t. John					/22/2010 Prince				
Ball	permit Depart Impor injury		21. Signature of Fu	neral Service I	icensee			Name and Add						ral Home	e, P.A.	
Ph	ysician				complications that caus	ed the death		• O • B							Approximate Interval	
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×	eath ce e attend for use	Physician/N		lo 9 🗸 Unki		at time of d	eath 5 Ot	her (Specify)	_				1			
f Vital Records, P.O. Box 68760,	at the d by the tached		Part II. Other signi	ficant condition	ons contributing to de		resulting in the u	underlying car	use give	en in Part I	l.	23e. Did to	bacco	use contribute to	the cause of death?	
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ital	sician: is certification	å	25. Was case referrexaminer?		Hospital: 1 Inp.	atient 2	FR/Outpatient		_	Death (Ch			Reside	ence 6 Othe	er.	
of ?	ing Physic After this uneral dir	O 1 Yes 2 No Inpatient 2 ENOutpatient 3 DOA Nursing Home 5 Residence 6 27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred														
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ivis.		Fed 3/16/10 Fd 12:01 and 1 residence    Accident   Accident   Investigation   Specify   Fd 3/16/10   Fd 12:01 and 1 residence   Could not be determined   Could not be determi										ural Route Number, City h Plave				
<b>.</b>	Hospital or 24 hours aft Funeral Di etely filled in	O 29a Certifier														
	To the Hospital within 24 hours To the Funeral completely filled	To be so the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  To be so the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  To be so the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  To be so the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  To be so the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  To be so the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  To be so the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  To be so the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
	- × - 3	ž	29b. Signature and	title of certifier					cense n				1	Date signed (M		
			20 No.				- 02-1	°	.C.M.	E.			Mar	rch 16, 2010		
	OCME				who completed cause of Deputy Chief Me			1 Penn Sti	reet, E	Baltimor	e, MD	21201				
	S	tate trar	Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  e 31. Date filed (Month, Day Year) 2 2010 32. Registrar's Signature  A Sauch													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and N	/lental Hygier	ne			
				ertificate of Death	Reg. i	No. 2010, 00201			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year 3. Time of Death			
	Medic	al	Charles F. Fadeley Sr.  4a. Facility Name (if not institution, give street and number)						
بر	Examin	er	, , , , , , , , , , , , , , , , , , , ,	4b. City, Town, or Location of Death	1 '	4c. County of Death			
1.186	Funeral		Asbury Solomons  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Solomons  y) If Under 1 Year I If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign			
	Director		235-28-6069   1 X M 2   F   87 Yrs	Months Days Hours Min.	03/20/192	22 West Virginia			
	d wo		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or						
	ryland -f sh	cto	100.00, 000.00			10d. Inside City Limits 1 ☐ Yes 2X No			
	e Ma r 28a notif	Director	Maryland Calvert Solo	nons 10f. Zip Code	1				
	vith th		11450 Asbury Circle # 409	20688	10g.	10g. Citizen of What Country?  USA			
	eath v tems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,			
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21215-0036	urs af tural" al Exa	ted	3 KJ Widowed 4 □ Divorced Year or Dates.	1 ☐ Yes 2 🛣 No Specify:		Specify: White			
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d	Hyg othe	Be	17. Father's Name (First, Middle, Last)	T	e (First, Middle, Maide				
Maryland	d be f denta urked tic ev	ျာ	Howard M. Fadeley	Georgi	la Champ	pe			
an	should and N is ma	1	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Run	al Route Number, City	or Town, State, Zip Code)			
≥,	nd 2 sealth m 27			54 Cherryfield Land	e, Drayden	, MD 20630			
Baltimore,	ye1a tofH Fite orott		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Discemetery, of the complete of Discemetery, of the complete of Discemetery, of the complete of Discements	sposition (Name of rematory or other place)	Date 20c.	. Location - City or Town, State			
ţ	t. Pag rtmen rtant:					. Mary's City, MD			
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Shawn Aylesworth M01521	22. Name and Address of Facility Br					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not	22955 Hollywood Repeter the mode of dving, such as cardiac		Approximate			
	Pnysician/	9 00	chack or heart failure. Liet only one cause on each line			Interval Between Onset and Death			
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-	Examiner		- moumon						
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760	cate be executed physician and s the burial-transit	edic	d						
<u>1</u> 89	ertific Iding se as	Ň/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			22d Data of delivery			
ŏ	atten atten I for u	iciar	in the past 12 months?  1  Live Birth 2 Fetal death 1  Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year			
Э.	the de by the ached	Physician/M	9 Unknown 9 Unknown						
P.	sician: The law requires that the death certific certificate has been signed by the attending rector, page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacci	o use contribute to the cause of death?			
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cor	aw re as be	Completed by	ANEURYSM OF ABJOMINA	HORTA	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of			
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) t	Phys ral dir	<u>ان</u>	1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outps 27. Manger of Death 28a, Date of injury 28b. Tim			6 ☐ Other (Specify)			
n o	nding th. : After e fune	Certificate:	1 Natural 5 Pending (Month, Day, Year) injured 2 Accident Investigation		28d. Describe how inj	jury occurred			
isio	Atter	ij	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office		and Number or Rural Route Number,			
Division of Vital Records, P.O. Box 687	tal or safte		building, etc. (Specify)		City or Town, Sta	ate)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check 2 Medical Examiner: On the basis of examination and/or in	th occured at the time, date and place, ar	nd due to the cause(s)	and manner as stated.			
	the Ithin 2.	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowled	ge, death occurred at the time, date and pla	ce, and due to the caus	se(s) and manner as stated.			
	5 ≥ 6 S		29b. Signature and title of certifier  AT Meerol MD	29c. License number  D 00019427		Date signed (Month, Day, Year)			
	•								
			30. Name and address of person who completed cause of death (Item 23a) (Typ	. ,	rederick	MD 20678			
	Sta	te	Anwar Munshi, M.D. 110 Hospit	hered	LUGITURS	20070			
	Registr	ar	2010	- William					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 03/02/2010 Physician 9:00 A M BERNADINE SILVERTA FRAZIER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Village 9965 Ridgeline Drive Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/14/1939 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2X F MD Director 213-40-926] 70 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show or than "natural", or Items 23a or 28a-f show the Wedical Evanther must be notified at 1 Yes 2 □ No Director MD Montgomery Montgomery Village 10g. Citizen of What Country? 10e. Street and Number USA 20886 9965 Ridgeline Drive Completed by Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify Specify: Black 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, Inc. M. Teacher's Aide Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Genevieve Davis Bernard Lancaster 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8106 Gorman Avenue, #226, Laurel, MD 20707 Cheryl Frazier - daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) Emory Grove Ch. Cem. 3/12/10 Gaithersburg, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or companies shock, or heart failure. List only not enter the mode of dying, such as cardiac or respiratory arrest, cations that caused the death. one cause on each line. Immediate Cause (Final disease or condition **Physician** YCOWS oncer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only ne) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number LUIS D112, M D0057984 March 4, 2010

State

Registrar

21287

BALDMORE

32. Registrar's Signature

30. Name and a press of person who completed cause of death (Item 23a) (Type, Print)

ORLEANS

MAR 08

31. Date filed (Month, Day, Year)

1650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Selma Yvette FRAGER Physician/ D2010 March 5. 8:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 5450 Whitley Park Terrace #310 Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. March Pay8 (ear) 1930 New York **Director** 79 578-34-0793 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Bethesda Montgomery Maryland 1 Yes 2 X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral United States 20814 5450 Whitley Park Terrace #310 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Chary Abraham Nadel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5450 Whitley Park Terrace #310, Bethesda, MD 19a. Informant's Name/Relationship (Type, Print) 20814 Arthur Frager, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 03/07/2010 Adelphi, MD Signature of Funeral 9 e Licensee forch that y Hebrew Funeral Home 20012 <u> 254 Carroll St., NW. Washington, DC</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebral Vascular Accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Lung Cancer 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an safter death.

I Director: After this certificate has the street of the street of the safe autopsy performed Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 \chi No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State า 24 hours a e Funeral L Medical 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Geftifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one 29c. License number Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chevy Chase, Md. 5530 Wisconsin Ave., Gary Figher, MD

State

31. Date filed (Month, Day, Year) MAR 08 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	State of M	aryland / De		nent of H			lental Hy	giene Reg. Ne	2010	092	207
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or I any liquy or other traumatic event, II. "Indical Eventone."		21. Signature of Fune	ral Service Licens	e e		1	2. Name and Addr FELLOWS OO SOUTH	HRI.FENRE	IN & NE	WNAM I	UNERAL	HOME, P.A.	
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GL TCK Month Sarah 201<u>0</u> March 5:43 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery <u>Sunrise of Silver Spring</u> Silver Spring If Under 1 Year If Under 24 Hrs. last birthday Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1 - M 2 - YF 93 Months Hours 216-07-0283 Director Mary and Aug Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or forther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗖 No Silver Spring Montgomery Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's United States Funeral 20902 9802 Georgia AVenue #202 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: white 3 XWidowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Worker Administrator Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Frankel ည Samuel Selden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Glick, Son 20902 9802 Georgia Ave., #202, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 03/1172010 <u>Nati</u>onal Capitol Heights, MD Capital Hebrew Cemetery 21. Signature of Funeral Senior 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home M01008 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter undersying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last -burial physician s the burial Physician/Medical certificate be 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown q 🗌 Unknown P.0. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Meningioma Records, cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an autopsy performed? 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Assisted 2 🗆 📉 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Living 28c. Injury at work?
1 ☐ Yes To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: injury 5 Pending 2 Accident 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nasreen Kango, M.D., 7701 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) MAR 1 1 2010 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death n 000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bessie Physician/ Greenberg Day 2010 ear 12:26 Am March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital Olney Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 T F Months New York Yrs Director 191 097-09-3440 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Broward FLMargate 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 480 N.W. 76th Avenue 33063 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "n:
any injury or other traumatic event, the Mexico (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Feinerman Barnett Friedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9412 Reach Road, Potomac, Maryland 20854 Jerrold Greenberg/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 😾 Burial 2 🗆 Cremation 3 🖈 Removal from State 4 Donation 5 Other (Specify) Star of David Mem.Grd 3/7/2010 N. Lauderdale, FL Signature of Funeral Service Licensee

U(() Well Melissa Greenhut
Mol1597 22. Name and Address o Danzansky-Goldberg Memorial Chapel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, Hypertension disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Dementia Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Usteoporosis Cause (Disease or linjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 L Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? this certificate 1 Yes 2 No Yes 2X No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 🛂 No Hospital: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA ျ 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 X Natural 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Af completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature and title of cer

Swaroop G.

31. Date filed (Month, Day, Year) NAR 08 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

82. Registrar's Signature

Rao,

29c. License number

D35792

50 W. Edmonston Drive #504, Rockville, Maryland 20852

29d. Date signed (Month, Day, Year)

March 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Nettie May GERDUK 2010 /Medical March 4. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring J.K. House of Grace 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 5, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2√□ F 1912 New Jersey 97 091-34-8395 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or United States 20853 1 Lake Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 P. 1 □ Yes 2 No Specify: If Yes, Give Year or Dates: \$ Specify: white 3X Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene.
n 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 20th Century Fund Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Kantor Julius May 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Lake Court, Rockville, MD 20853 permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Irwin Gerduk, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Beth Israel Cemetery :03/09/2010 | Woodbridge, NJ</u> 21. Signature of Fune al Service Licensee ชื่อใช้กราหรับระที่ยี่มีพอพ Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line rset and Death Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 7 Years Renal Insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Completed by Physician/Medical e asn IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ (No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specific Assisted 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Medical Certification: To <del>Living</del> 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day, Year) Injury 1 X Natural 5 ☐ Pending n 24 hours after death.

le Funeral Director: Af
bletely filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) npletely To the I within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ett Marries March 5, 2010 D 47682 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bennett Morrison, M.D., 2901 Olney-Sandy Spring Road, Olney, MD 20832 31. Date filed (Month, Day, Year) State 32. Registrar's Signature backed Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month-2 CHARLES HOWARD 7:40PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Ellicott City Health & Rehab. Ellicott City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days Hours 1^M70271⁹³5 Mary Tand Director 217-34-1107 74 Yrs Usual Residence of Decedent or 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert 1 🗆 Yes 2 🖾 No Huntingtown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2995 Carroll Road 20639 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed white Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 butcher retail grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walton John Benjamin Howard Irene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a ant: If item 27 is Margaret Howard, wife 5623 Catoctin Ridge Drive, Mt. Airy, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Memorial Gardens 03/12/2010 | Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Propal Bilateral neumanis Medical Examiner 1-nd orage Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequer Exami The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinium that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year the 9 Unknown 9 Unknown ģ signed } Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ ک Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending n 24 hours after death.

Funeral Director: Aft 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed To the I within 2 To the I 29b. Signature and title of certifier D50641 deRW 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) REVERNECE Read Baltimore MD21221

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Back

201- (29

Kamesh Sabapalmi

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marialee Borbajo ^D2010 Jorda March 5, 3:45 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days Month, Day, Ye April 4, 1 □ M 2 🖾 F Philippines 217-39-8198 Director 35 1974 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏻 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13219 Vandalia Drive 20853 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give "natural", or 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
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any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Celerino Borbajo Ligaya Supapo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13219 Vandalia Drive, Rockville, MD 20853 Rodulfo Mel A. Jorda/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. March 2010 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland . Signature of Juneral Service Libensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Metastatic Cervical Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending physi IF FEMALE 23c. If yes, outcome of pregnancy
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the Funeral Director: After mpleted filled in by the fun 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 40064588 -6-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Ashish Tolia, MD

State Registrar 31. Date filed

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 4:45 p M Herbert Edward Johnson March 7, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13605 Dowell Road Dowell Calvert If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs. Director 216-32-0265 74 October 20, 1935 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show. 1 ☐ Yes 2 No Director MD Calvert Dowell 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13605 Dowell Road 20629 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: ģ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 Is marked other the any Injury or other trailmasts. 12 Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Johnson 0 Verna Foote 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Johnson - wife 13605 Dowell Road, Dowell, MD 20629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John UM Church Cem. | March 13, 2010 | Lusby, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sewell Funeral Home, P.A. Glady 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Years rostate Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 55 Residence 6 Other (Specify) 1 Yes 25€No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation * Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide t Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

drugt1

OLVON,

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MD

32. Registrar Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gwyneth Blattau, MO 110 Hospital Rd #5,

12 2010

29c. License number

29d. Date signed (Month, Day, Year)

rince Frederick MD 20678

State Registrar 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year March 7, Joseph James Johnson 7:00A. M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Village Silver Spring Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Aug. 29, 1926 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X** M 2□ F Days Hours 83 Missouri 213-20-9582 Yrs **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Exambler , ust be nother 1 ☐ Yes 2 No Maryland Silver Spring Directo Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3122 Gracefield Road, CT504 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 1944-1946 Year or Dates! Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2XNo White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4o-5+) Veterinarian Veterinary Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental int; If Item 27 is marked o Harry Johnson Della Wurdeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3114 Gracefield Road, WC307 Silver Spring, MD 20904 Bernice B. Johnson -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Memorial Gdns.3/15/2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Landd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Congestive Cardiomyopathy /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and as the burial-tra Due to (or as a consequence of) of Vital Records, P.O. Box 68760 physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 No Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a Was an has autopsy performed? Yes 20 No certificate 1 □Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No Certification: To this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 1 Division 1. Natural 5 Pending investigation in 24 hours after death.
The Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dean B. Jack

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Tosenh

Andrew Kundrat, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

D36716

March 8, 2010

Division of Vital Records, P.O. Box 68760 of the Hospital or Attending Physician: The law requires that the death certificate be executed above of the death.	~	Phy N Exa
	Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death

		Please Type or Print in Black In State of Maryland / Depa			
	1	_ For	tificate of Death		g. No.2010 09217
Physician Medica	/	1. Decedent's Name (First, Middle, Last)  RHONDA ELLEN JACKSON		2. Date of Death Month March	Day Year 3. Time of Death 1627 M
Examine	_	4a. Facility Name (if not institution, give street and number)  Memorial Hospital	4b. City, Town, or Location of		4c. County of Death
Funeral	5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 M 2 <b>X</b> F 57 Yrs.	If Under 1 Year If Under 2 Months Days Hours		9. Birthplace (State or Foreign Country) MARYLAND
Director ≽	- 1-	Usual Residence of Decedent		2/23/19	
aryland a-f sho ffied at	ector	10a. State         10b. County         10c. City, Town or Loc           MD         TALBOT         EASTON	ation		10d. Inside City Limits 1 <b>X</b> Yes 2 □ No
h the M ka or 28 be noti	Funeral Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
ems 23	nue	815 ARCADIA STREET           11. Marital Status         12. Was Decedent Ever in U.S.         13. W	21601 Vas Decedent of Hispanic Orig	in? (Specify Yes or No-	USA 14. Race - American Indian,
	Completed by I	1 X Never Married 2 Married 1 Yes 2 X No	Yes, specify Cuban, Mexican,  Yes 2 No Specify:	Puerto Ricari, etc.)	Black, White, etc. Specify: WHITE
72 hou	mplet	(Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most O NOT use retired)	of working	6b. Kind of Business Industry
d withir lygiene lygiene the the l	a l	10 0 WAIT	RESS 10 Mothe	r's Name (First, Middle, Ma	FOOD SERVICE
yiand d be filed Mental Hy arked ott	9	17. Father's Name (First, Middle, Last)  ELWOOD ROBERT JACKSON, SR.		DELINE SULLI	
d 2 should alth and N 27 is me er trauma		19a. Informant's Name/Relationship (Type, Print)  CHARLES R. JACKSON/SON  19b. Mailin 11	g Address (Street and Number 1 OAKLEY STRE	r or Rural Route Number, C ET, CAMBRIDG	City or Town, State, Zip Code)
Page 1 and Page 1 and nent of Hea ant: If item iry or other		20a. Method of Disposition  1	natory or other place) i	Date 2 3/13/2010	EASTON, MARYLAND
baltimore bermit. Page 1 s Department of H Important: If ite any injury or ot		Katta Lallo		BEIN & NEWN	AM FUNERAL HOME, P.A.
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	or the mode of dying, such as t	cardiac or respiratory arres	t, <b>KASTON, MD</b> Approximate Interval Between Onset and Death
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	xuctive puls	mory das	eise yeurs
Examiner	_	Sequentially list conditions.  b. to bucco U	ise	· · · · · · · · · · · · · · · · · · ·	yeun
ted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury			
e executed cian and urial-transi	<u> </u>	that initiated events resulting in death) Last  C.  Due to (or as a consequence of):			
<b>68 / 60</b> certificate b nding physic use as the b	Vedic	d			
ords, P.O. Box 68/60 v requires that the death certificate be executed the been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medic	IF FEMALE:   23b. Was decedent pregnant   1	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the usual complete pulmary fiber	,	. 23e. Did tob	acco use contribute to the cause of death?
Division of Vital Records, all or Attending Physician: The law requires s after death.  Indirector: After this certificate has been signed in by the funeral director, page 2 should be in by the funeral director, page 2.	Completed by	hypertension		24a. Was an autops perform	prior to completion of cause of death?
al R	Be Co	25. Was case referred to medical examiner?	26. Place of Deat	1 ☐ Yes 2 th (Check only one)	1 Yes 2 No
f Vit Physic this ce ral direc	မ	Hospital: 1   Impatient 2   ER/Outpatier		ursing Home 5 Reside	
on o ending sath. or: After he fune	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury	work? M 1 ☐ Yes 2 ☐	No	
iviSi or Atte after de Directe		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Str City or Town	eet and Number or Rural Route Number, State)
le Hospita 124 hours le Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investignty only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death oc	curred at the time, date and	d place, and due to the cause(s) and manner stated.
To th within To th comp	~	29b. Signature and title of certifier	29c. License number	13	9d. Date signed (Month, Day, Year)
10		only one) 3 Certifying Nurse Practioner: To the best of my knowledge,  29b. Signature and title of certifier  7 30. Name and address of person who completed cause of death (Item 23a) (Type, If Marie W. Martin W. 219 South  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ci kishnich S	Heel EAS	Tun 12 21601
Stat	е	31. Date filed (Month, Day, Year)  32. Registrar's Signature	la de la	, , ,	(
Registra	ır	MAR 1 0 2010 Senera B.			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ MI 0 arch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner zabeth Ursing enter a timor 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, 1 M 2 👿 F Months Hours Min. MASSACHUSETTS Director 018-22-9656 81 928 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location Examiner must be notified at Director 10d. Inside City Limits 28a-f Y Yes 2 No SILVER SPRING MONTGOMERY MD. 10e. Street and Number 10g. Citizen of What Country? ö 10f. Zip Code items 23a Funeral 13920 CASTLE BLVD. 20904 U.S.A. death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 Divorced WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) the PAINT MANUFACTURER CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည COLLIS WILLIAM **JAMES** LUCY ADELAIDE GARLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MARGARET J. KAHLOR/DAUGHTER 6446 ELIBANK DR., ELKRIDGE, 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY 3-5-2010 RIVERDALE, 21. Signature of Funeral Service Licensee AL HOME & CREMATORIUM, P.A. AVE., RIVERDALE, MD. 20737 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final obstructive Physician, hronic monary disease disease or condition resulting in death) Medical Duy to (or as a consequence of): Examiner ension em Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (*r * a consequence of): sician and burial-transit month Ishh that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last physician Physician/Medical Box 68760 the attending as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No ō Month Day Year Pregnant at time of death detached the P.O. ò s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autops, performed: 2 No death? 1 Yes 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical within 24 hou

To the Fune

completed fil 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ္ 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) timore MO 33 20 State

Registrar

Amended item #26 per Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. physician, 03/12/2010;cs State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Physician Year 8, 2010 William Junior Kessel March 3:35 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Memorial Hospital 0akland Garrett If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 □ F 236-68-2529 Director 11/16/1941 WV Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Director 1 ☐ Yes 2 No WV Grant Mt. Storm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examination and be HC76, Box 540 26739 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2X☐No Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Coal Mining Expands 1 and 2 should be filed with the not of Health and Mental Hygie tant: If Item 27 is marked other talury or other traumatic event, Its 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arlie William Kessel Evelyn Keplinger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is any Injury or other trau once. Gloria Kessel, Wife HC76, Box 540, Mt. Storm, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/11/2010 Mt. Storm Cemetery Mt. Storm, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, 21 N. Second St., Oakland, MD Katherine 23a. Part 1. Enter the disease, or complications that valsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNGESTVE /Medical Due to (or as a consequence of) Examiner URUNARY Eague, then, there or differen-if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical PRRLIPIONEM After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Proceeding 6 Other (Specify) 1∐Yes 2**X**ÎNo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nt. STURM, WV 26739 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician March 11, 2010 5:45 Mary Margaret Knox /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Garrett Goodwill Mennonite Home Grantsville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 X F 1911 Maryland 98 July 28, Director 216-40-3295 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nedical Exeminal must be a diffied at 1 ☐ Yes 2 X No Director Grantsville Garrett death with the 10g. Citizen of What Country? Of. Zip Code 10e. Street and Number USA 21536 1074 Zehner Rd. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Pages 1 and 2 should be filed within 72 hours after a nent of Health and Mental Hygiene. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Canner Meat Packing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Menta item 27 Is marked Elizabeth Opel Clarence Calvin Stephen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10903 Rawley Rd., New Market, MD Hazel V. Green/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages Department of Important: If it any Injury or or 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glade Cemetery March 13, 2010 Accident, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Services 22. Name and Address of Facility Newman Funeral Homes, P.A. Cletnon me P.O. Box 275, Grantsville, MD 04 Approximate Interval Between Onset and Death 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) , /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if an leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami and the burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☑ No is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 1 □ Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 🗖 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death.

I Director: Af d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

24 hours a within 24 hor To the Fune completely f

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson, 311 N. 4th St., Oakland, MD MAR 1 2 2010 32. Registrar's Signature

State Registra

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

29c. License number

DC 3333

29d. Date signed (Month, Day, Year)

100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Degedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:25A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arundel Anne Arundel Medical Center Annapol Security Number 9. Birthplace (State or Foreign Country)
N • C • 6. Sex If Under 1 Year If Onder 24 Hrs. 8. Date of Birth Funeral 1 DM 2 1 (Month, Day, Year) 2-28-1919 Hours Director 238-24-7883 90 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Md. Anne Arundel 1 Yes 2 No Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1502-C Flanders Lane USA 20776 within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates should be filed within 72 hours afte and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: Black Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) home Elementary/Seconday (0-12) College (1-4 or 5+) someone else's Home maker injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Fox Thompson Lillian and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary McCannon / 1502 C Flanders Lane, Harwood, Md. 20776 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Cemetery Dover, De. 03-15-10 22. Name and Address of Facility
Bennie Smith Funeral
524 Race St., Cambridge, Md. 21613 Signature of Fuxral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ritica Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 Who
9 Unknown Day 5 Other (specify) Month Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopo, performed? 2 1 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Yes 2 **N**0 1 Prinpatient 2 ER/Outpatient 3 DOA Manner of Death
1 Watural
2 Accident 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending or . as after dea. eral Director: A[‡] اللاط in by thr 1 Yes 2 No Accident Investigation M 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D completed filled is Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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Name and address of person

MAR 1 0 2010

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year PM Judy C. Liberatore March 2010 5:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Stella Maris Hospice Center</u> Baltimore Timonium If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. (Month, Day, Year Director 215-48-1681 07/20/1946 Maruland Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Havre de Graco MD Harford 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 848 Otsego Street U.S.A "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death ^o Department of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Force 1 Never Married 2 Married ☐ Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced er than "nature ; the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturina is marked other aumatic event, th Purchasina Aaeni Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry R. Leasure Rachel I. Yokum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Joseph Liberatore, Jr (husband) 848 Otsego St., Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 03/12/2010 | Darlington, MD 22. Name and Address of Facility Zellman Funeral Home. P.A. 123 S. Washington St., Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificate filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident s after death Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title erson who completed cause of death (Item 23a) (Type, Print)

State Registrar

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			For State	State o	f Mai	ryland /	*			lealth a Death	and M	ental Hy	•			
	.50.1		Registrar  1. Decedent's Name (First, Middle, La	.st)			001	moan	011	Jean		2. Date of De	Reg. No.	2410	3. Time of Death-	
н	Physici		Nettie Alice Lamb								İ	Month March	Day	Year 10	8:30 P M	
	/Medic Examir		4a. Facility Name (If not institution, giv		mber)			4b. City,	Town, or	Location o	of Death	rial Cii		County of Death	10:30 F	
100			Dennett Road Mano	r Nursi	r Nursing Home Oak								Ga	rrett		
	Funeral		Social Security Number     6. S	(In yrs. last t		If Under Months	1 Year	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthp	place (State or Foreign			
	Director		234-68-4618	1□M 2∏F	93		Yrs.			1100.0		05/24/			Virginia	
	and w		Usual Residence of Decedent  10a, State 10b, County			10c. City, To	wn or Loc	ation							10d. Inside City Limits	
	Marylar f show	5	MD Garrett			0akla	nd								M∑Yes 2 No	
	the 28a-	Director	10e. Street and Number			Oukiu	114	10f. Zip	Code				10g. Citize	en of What Cour	ntry?	
	3a ol	O E	1113 Mary Drive						2155	50		United States				
	deat	Funeral	11. Marital Status	12. Was Dece	edent Ev	er in U.S.	13. V	Vas Deced	dent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	)- 14	4. Race - Americ Black, White,		
9	after or ite		1 Never Married 2 Married	1 ☐ Yes If Yes, Gi	2X No	)		☐ Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,	i noarn, oto.)		Specify:Whit		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	d by	3 Widowed 4 □ Divorced	Year or D	ates:											
15-	n 72 l "nat edica	Completed	15. Decedent's E (Specify only highest gr	ade completed)			(Give F	ent's Usua kind of wor O NOT us	rk done d	durina mosi	t of worki	ng	160. Kind	d of Business/In	dustry	
12	withi iene. than	mo	Elementary/Secondary (0-12)	College (	1-4or 5+	)		emake		7			Own	Home		
	Hyg Hyg other ent, i	BeC	17. Father's Name (First, Middle, Last	')						18. Mothe	r's Name	(First, Middle	, Maiden S	Surname)		
lan	Jid be Jenta Jenta rked ric ev	To B	George William Ga	y						Roset	ta E	lorenc	e Hol	.loway		
Maryland	12 should be filed w h and Mental Hygie 7 is marked other t traumatic event, th		19a. Informant's Name/Relationship	Type. Print)		15	9b. Mailin	g Address	(Street	and Numbe	er or Rura	il Route Numb	er, City or	Town, State, Zip	Code)	
	and and n 27		Geraldine Nasser,	Daught	er					West		ort, M				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygtene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shorany hijury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition    ↑ Burial 2 ☐ Cremation 3 ☐	Removal from	State		tery, crem	natory or o	ther plac		_	Pate		ation - City or To	own, State	
Ë	permit. Page Department of Important: If any Injury or once.		4 Donation 5 ☐ Other (Speci	fy)		Bayar			-			7/2010				
Baj	permit Depar Impor any In		21. Signature of Funeral Service Lice	nsee										k Funer	al Home	
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9	Physician /Medical Examiner	Examiner	shock, or heart failure. List only one cause of feach line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											Onset and Death		
,68760,	The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	dical	that initiated events resulting in death) Last	Due to	(or as a	consequenc	ee of):									
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	w requires that the de been signed by the s should be detached t	by	Part II. Other significant conditions	contributing to d	eath but	not resulting	in the un	derlying c	ause give	en in Part I.				e contribute to t	the cause of death? bably 4 □Unknown	
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or Vital	Physral di	은	1 Yes 2 No 27. Manner of Death	28a. Date		t 2 ER/0	Outpatient o. Time of		)A	41-NU		me 5 Res 28d. Describe		Other (Special	fy)	
	ding Ph. h. After th	흲	1 Natural 5 Pending 2 Accident investigatio	(Mon	th, Day	Year)	Injury	м	8c. Injur Worl 1 □	k? Yes 2⊟I		Log. Dogonbo	now injury	occurred		
Division	spital or Attending nours after death. neral Director: After filled in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place	of injur	y - At home, (Specify)	farm, stre	eet, factory	, office				(Street and wn, State)	Number or Run	al Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 ☐ Certifying Pi (Check only one) 2 ☐ Medical Exa	hysician: To the miner: On the b and man	asis of e	examination	lge, death and/or inv	occurred restigation	at the tir n, in my o	ne, date an ppinion, dea	id place, ith occurr	and due to the red at the time	cause(s) a , date and	and manner as s place, and due t	stated. to the cause(s)	
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			> +t/x	lun.					T	)15	33	3	3	1511	C	
		2	30. Name and address of person who	completed caus	se of dea	ath (Item 23a	a) (Type, F	Print)						1		
		2	Dr. Thomas G. J				Four	th S	tree	t, 0a	k1an	d, MD	21550			
	Sta Regist	_	31. Date filed (Month, Day, Year)  MAR - 9 2011		Registrar	's Signature	bou	W								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Samue1 Boddie Movle, III 2010 12:00 a.M Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Hospice House of St. Mary's Callaway St. Mary's Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year, 05/20/195. 1 X M 2 □ F Days Hours Min. South Carolina Director 250-86-2210 58 Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important if item 27 is marked other than "naturo" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 23120 Marshall Road 20653 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married Black, White, etc. If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Analyst Defense Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Boddie Moyle, Jr. Mary Helen Gilmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara H. Moyle/Wife 23120 Marshall Road, Lexington Park, 20653 MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oconee Memorial Park 03/21/2010 Seneca, SC Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Shawn Aylesworth M01521 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical De to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ເເລົ້າNo 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate I 2 🗌 No 1 🗌 Yes 25. Was case referred to medical filled in by the funeral director, æ 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) HO055751 of person who completed cause of death (Item 23a) (Type, Print)

(and

DHMH 17 Rev 7/2009

State Registrar Jennifer Schmidt,

31. Date filed (Month, Day, Year)

D.O.

32. Registrar's Signature

40900 Merchants Lane, Leonardtown, MD 20650

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State C	i wai yiai		tificate of D		ientai Hy	Reg. No	0011	1 00225
	Discolate	- 1	Decedent's Name (First, Middle	e, Last)					2. Date of De	ath	-	3. Time of Death
	Physicia Medic		Cindy Lou Monts	gomery	**				Feb 27,	2010	Year	3:10 a M
	Examin	er	4a. Facility Name (if not institution		iber)			Location of Death			County of Dea	
. ~	Funeral		Shady Grove Ho 5. Social Security Number	ospital  6.Sex	7. Age (In yrs.	last hirthday)	Rockvil	Le If Under 24 Hrs.	8. Date of Birl		ntgome	thplace (State or Foreign
	Funeral Director		219-78-7233 Usual Residence of Decedent	1 □ M 2 🔀 F	ge (m yrd.	49 _{Yrs.}	Months Days		(Month, Da Aug 4	960	Mai	unity) cyland
	show dat	tor	10a. State 10b. County		10c. Ci	ty, Town or Loc	cation					10d. Inside City Limits
	Mary 28a-f otifie	Director	MD Montgo	omery	Gai	thersbu	ırg					1 🗆 Yes 2 🔀 No
	h the Saor ben		10e. Street and Number				10f. Zip Code				izen of What Co	•
	th wit	Funeral	8203 Morning		4.15	0 40.0	20877				ed Sta	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	by	11. Marital Status  1 ☼ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	rried 1 Yes	2 😾 No e		Vas Decedent of Hi f Yes, specify Cubar I ☐ Yes 2 🔯 No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	ecity Yes or No- Rican, etc.)	es or No- , etc.) 14. Race - An Black, Wh Specify.Cau		e, etc.
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/lar	Frazier Newton Montgomery Elizabeth Blanch Red									Redmon		
Maryland 21215-0036	d 2 should alth and Me 27 is marl er traumati		19a. Informant's Name/Relations Bonnie Carli		er	1		nd Number or Rura Rock Dri				o Code) n, MD 20874
Baltimore,	permit. Page 1 and Department of Heal Important: If item ' any injury or other		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (\$		State	cemetery, cren ort Lin	sition (Name of natory or other place	matory 3/	Date 9/10	Brei	ntwood,	
Balt	permit. Departimporting		21. Signature of Foreral Service I		01463			s of Facility Sim				0852
			23a. Part 1. 1 Iter the disease, or shock or heart failure. List of	complications that of	aused the deat	h. Do not ente	er the mode of dying	g, such as cardiac o	or respiratory an	rest,		Approximate Interval Between
	Priysician/		Immediate Ause Final disease or ondition			erotic	Cardiova	scular Di	Lsease		93	Onset and Death years
-	Medical Examiner		resulting in death)		or as a conseq abetes		15					years
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8760	ificate ng phy as the	Med	IF FEMALE:							- 1		-
P.O. Box 68	he death certific y the attending p ched for use as		23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 🔀 Unknown	1 Live	come of pregna Birth 2  Fet nant at time of lown	al death 3 🗆	Ectopic pregnance Other (specify)	у			23d. Date of de Month	livery Day Year
ls, P.0	requires that the de been signed by the should be detached	<u>ا ک</u>	Part II. Other significant condition	ons contributing to d	eath but not res	sulting in the u	nderlying cause give	en in Part I.				the cause of death?
orc	w requires been 2 shou	Completed							24a. Was		24b. Were au	topsy findings available
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ta	<u>≅</u> ≝ ∺	Be	25. Was case referred to medical examiner?	Hospital:				ace of Death (Check	only one)			
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£	Physician: The law this certificate has tal director, page 2 s	၉	1 X Yes 2 No	1 🗆			00- 1-1					
ion of V	ending Physicia eath. or: After this cert the funeral direct	၉	27. Manner of Death  1 Natural 5 Pendir 2 Accident Investi	28a. Date (Monting gation		28b. Time of injury	28c. Injury work? M 1 □	at 2	28d. Describe h	ow injury	occurred	
Division of V	al or Attending Physician: The law requires that the death certificate be executed s's after death.  I Director: After this certificate has been signed by the attending physician and ed in by the funeral director, page 2 should be detached for use as the burial-transi	Certificate: To	27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date (Monting gation not be 28e. Place	of injury h, Day, Year)	28b. Time of injury	work	at ? Yes 2 🗆 No	28d. Describe h	itreet and		ral Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03/02/2010 М DARRELL ANTHONY MCDONALD 1104 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Montgomery Rockville Birthplace (State or Foreign Country)
 MD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Days Director 216-60-1788 57 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1X Yes 2 ☐ No Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4011 Plyers Mill Road 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Hygiene. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Completed 3 Widowed 4 Divorced Black Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Line Worker Government and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ဂ္ James McDonald Gertrude Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James McDonald - father 4011 Plyers Mill Road, Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Dongtin 5 Other (Specify) y, crematory or other place) Gat 3/10/10 olf Heaven Cem. Silver Spring, MD 21. Signatury of Juneral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ations that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Priysician/ Myocardia # infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death Unknown Yes 2 No ed by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed t 23e. Did tobacco use contribute to the cause of death? þ has been sig ge 2 should b Completed 1 Yes 2 No 3 Probably 4 X Unknown Were autopsy findings available prior to completion of cause of autopsy page performed? death? certificate 2 X No 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No 1 Tyes 1 Inpatient 2X ER/Outpatient 3 IDOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) After this o 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work' 5 Pending 1 ☐ Yes 2 ☐ No death. Accident Suicide Investigation neral Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral E

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 2, 2010

Registrar DHMH 17 Rev 7/2009

State

Coure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

medical

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Registrar's Signatu

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		For St <i>a</i> te Registrar				tificate of			Reg. No.	2010	09227
Physi	cian	1. Decedent's Name (First, Middle, Last	)					2. Date of Dea		Year Year	3. Time of Death
/Med		Alice Jun		Mc(	Ginn:			March		2010	11:30 AM
Exam	iner	4a. Facility Name (If not institution, give	street and number)				r Location of Death Frederick			ounty of Deatl $alvert$	h
Funer	al a	5. Sour security Number vert 5. Se		use e (In yrs. last b	irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birtl	hplace (State or Foreign
Directo		578-14-8476	□M 2啓F	90	Yrs.	Months Days	Hours Min.	(Month, Day 02/22/	1920	Oh	untry) LO
and w		Usual Residence of Decedent  10a, State 10b. County		10c. City, Tov	wn or Loc	cation		<u> </u>			10d. Inside City Limits
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th wit		1650 Walnut Road				20676	ó		Uni	ted Sta	ates
er dea Items	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of H Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	- 14	I. Race - Ame Black, White	
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d be f ental ked o	To Be	Edward Mort					Mamie	_ '			
shoul and M s mar	-	19a. Informant's Name/Relationship (7)	ype. Print)	19	b. Mailin	g Address (Street	and Number or Ru	ral Route Numbe	er, City or	Town, State, 2	Zip Code)
and 2 ealth n 27 i		C. Edward McGinnis	ss- spouse	10	650	Walnut Re	d. Port R	epublic			
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, in a Medical any injury or other traumatic event, in a Medical and injury or other traumatic event, in a Medical and injury or other traumatic event, in a Medical and injury or other traumatic event, in a Medical and injury or other traumatic event, in a Medical and injury or other traumatic event, in a Medical and injury or other traumatic event, in a Medical and injury or other traumatic event, in a Medical and injury or other traumatic event, in a Medical and injury or other traumatic event.		20a. Method of Disposition 1 ☐ Burial 2 😿 Cremation 3 ☐		20b. Place cemet	of Dispos	sition (Name of natory or other place tan Fund	e) 03/12/2 ral Servi	O10		ation - City or	
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/Medica		resulting in death)	Due to (or as	a consequence	e of):	.1		lye 10001sa	}	Decen	11
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The law requires that the death certificate be attending by the attending physicia bage 2 should be detached for use as the buri	sician/Medical	IF FEMALE:	23c. If yes, outcome	of pregnancy					99	3d. Date of del	livory
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ng Phy fter thi	n: T	27. Manger of Death  1 ✓ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28b	. Time of Injury			28d. Describe h			House
tendii leath. Ior: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be				M 1□	Yes 2 □No				
or At after c Direct in by	ertification:	4 ☐ Homicide determined	28e. Place of Inju	ury - At home, c. <i>(Specify)</i>	tarm, stre	eet, factory, office		28f. Location (8 City or Tov	Street and wn, State)	Number or Ri	ural Route Number,
	100	1									
bours hours neral y filled	a C	29a. Certifier Certifying Ph	ysician: To the best	of my knowled	ge, death	occurred at the t	me, date and place	, and due to the	cause(s)	and manner a	s stated.
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier (Check only one)  Certifying Phyone)  Medical Examonation of title of certifier	ysician: To the best liner: On the basis of and manner sta	of examination a	ge, death and/or inv	occurred at the tivestigation, in my	opinion, death occu	rred at the time,	date and p	and manner as place, and due signed (Mont.	e to the cause(s)

den 5 State 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Lowenthal, MD Hospital Rd. Prince Frederick, MD 20678

31. Date filed (Month, Day, Year)

NAR 12 2010

Lineur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Jeffrey James Miskell 10 11:15 PM March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 100 W. Main Street Middletown Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. (Month, Day, Year, Country) Director 299-42-6088 1952 <u>June</u> 1 Wisconsin Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 X Yes 2 No Maryland Frederick Middletown 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 100 W. Main Street United States items death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ō 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Divorced 4 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5± Carpenter/Designer Design Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miskell Fav Elizabeth Sharp Jeanne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Judi Kay Miskell/wife 100 W. Main Street Middletown, Maryland 21769 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 3/12/2010 Woodbine, Maryland 21. Signeture of Funeral Service Li 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M00957 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Asystole seconds Medical resulting in death) Due to (or as a consequence of): Examiner Hypoxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events minutes Due to (or as a consequence of): Exami that the death certificate be executed Apnea sician and burial-trans minutes Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Intracranial hemorrhage davs IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Metastatic Lung Cancer (no biopsy diagnosis) Records, or Attending Physician: The law requires 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Brain Metastases iis certificate has director, page 2: autopsy performed' death? 1 Yes 2 No Yes 2 X N Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tyes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. (Month, Day, Year) 1X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29a. Certifier

only one)

29b. Signature and title of certifie

MD

strar's Signature merchan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 0067442

Frederick, Maryland 21702

46B Thomas Johnson Drive Suite 200

29d. Date signed (Month,

2010

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 _ State		State	of Maryla		artment of H		and Me	ental Hyg	giene		
			Registrar	7 A . B 47-1-H-	I not)		Cei	tificate of L	Death			Reg. No.	2010	1,09229
н	Physicia	in/	1. Decedent's Name (F)  Ernest K.								2. Date of Dea Month Mar •	ath Pô	2010	3. Time of Death 6:25pM
	Medic Examir		4a. Facility Name (if not			mber)		4b. City, Town, or	r Location of		ria I •		County of Dear	
nge d'			70 Woodsi		ive			Chesape				1	ecil	
	Funeral Director		5. Social Security Numb	1	6. Sex 1 💢 M 2 □ F	7. Age (în yr	rs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 2 Hours		B. Date of Birt (Month, Day ay 13,	h ( Year) 4	9. Bir Co	thplace (State or Foreign untry) DE
	nd now	ŗ	Usual Residence of Dec 10a. State 10	cedent b. County		10c.	City, Town or Lo	cation						10d. Inside City Limits
	larylar 3a-f sl	Funeral Director	MD	Ceci1			Chesapea							1 ☐ Yes 2 😾 No
	the M	١	10e. Street and Number				onesapea	10f. Zip Code				10g. Citi	izen of What Co	
	s 23a	Jera	70 Woodsi	de Dr	Lve			21915				USA		
	death r item ner n	Ē	11. Marital Status	- (*hr	Armed Fo	edent Ever in orces?		Was Decedent of H f Yes, specify Cuba	ispanic Origi In, Mexican,	in? (Specif	y Yes or No- can, etc.)		14. Race - Ame Black, White	
36	al", or	d by	1 Never Married 3 Widowed 4		ed 1 ∐ Yes If Yes, Gi Year or D	2 <b>X</b> No ve		☐ Yes 2 ☐XNo	Specify:				Specify: wh	
9	hours natur lical E	lete	15	5. Decedent	's Education			fent's Usual Occup					nd of Business	
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ary.	nd Me		Ernest K. Magaw Sr. Florence C. Delahunty  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State										n Codel	
ž	d 2 st alth a n 27 is er tra		Laura V. 1	Magaw	/ wife			odeside						,
Baltimore,	of He of He If iten or oth		20a. Method of Disposit		B Removal from	20t	o. Place of Dispo		<u> </u>	3/16/2			cation - City or	
ij	Page tment tant: jury o		4 Donation 5					d Funera	1 Home	P. P.	A.	Ris	ing Sun	, MD
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Once.		21. Signature of Funeral Service License  22. Name and Address of Facility R.T. Foard and Gee 259 E. Main St. Elkton, MD 21921										921	
23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause or each line.											Approximate Interval Between			
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mark!	Medical Examiner		resulting in death)	- 1	Due to	(or as a cons	equence of):			N.	1			
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	uted id ansit	Examiner	dany, leading to immediate. Enter Underlying Cause (Disease or injusthat initiated events	ig iry	с									
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687	sertific Iding I	Ň/W	IF FEMALE: 23b. Was decedent pred	onant	23c. If yes, ou	tcome of preg	nancy						22d Date of de	livon
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s, P.O.	ires that signed d be de	by	Part II. Other significan	nt condition	s contributing to o	death but not	resulting in the u	nderlying cause giv	en in Part I.					the cause of death?
of Vital Records,	v requ	Completed									24a. Was a		24b. Were au	topsy findings available
3ec	The lay ate hay bage 2	lmo:									autop perfor 1  Yes	med?	prior to death?	completion of cause of
E	sian: T ertifica ctor, p		25. Was case referred to examiner?	o medical				26. Pla	ace of Death	n (Check or		2 🗆 140	1 1 100	2 110
Ξ	Physic this co	은	1 ☐ Yes 2 ☑ No	0			☐ ER/Outpatier		4 □ Nur	sing Home	5 Resid	ence 6	Other (Spec	ify)
n o	ding F h. After funer	Certificate:	27. Manner of Death  1 Natural 5 2 Accident	Pending	,	of injury oth, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗔	∕at ? Yes 2 □ N		d. Describe ho	ow injury	occurred	
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Division	tal or safter al Director		4 🗀 Hollicide	determin		ing, etc. (Spec					City or Town		7707.1207 01 7101	ar rioute (torribol)
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Uneck 2 🗀 i	Medical Ex	aminer: On the bas	sis of examina	tion and/or invest	ccured at the time, igation, in my opinio leath occurred at the	n, death occ	curred at the	e time, date ar	nd place,	and due to the	cause(s) and manner stated.
	Vithi Vot	~	29b. Signature and title	of Prtifier	ider-5.			29c. License	number		- 2	29d. Date	signed (Month	n, Day, Year)
	ð		30. Name and address of	of person w	no completed caus	se of death (It	em 23a) (Type, P	rint)	EDL.7	to N	1021.	<i></i>		
	₹ Stat		31. Date filed (Month, Da	aold day, Year)		Registrar's Sig	1 E flight	, 01 /	UPRY	V 81 001	الدن	721		
	Registra				2 2010	2		base						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 5:10 pm Pamela Hyacinth Moses March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15020 Wellwood Road Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Days 1 M 2 X F Hours Min 02/26/1935 215-50-5843 Director 75 India Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15020 Wellwood Road 20905 U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black White etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Asian Indian Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72., h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Secretary World Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Paul Ellore Josephine Roberts injury or other traumatic and 2 should be Health and Mer tem 27 is market 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ebenezer Gnanaraj Moses - Spouse 15020 Wellwood Road, Silver Spring, MD 20905 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other th 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) George Washington Cem 03/11/2010 | Adelphi, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service 11800 New Hampshire Ave., Silver Spring, MD 20904 23a: Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hroni phocytic leukemia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) MENTH Examiner ARDIOM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Ducito (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and-tran Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, the Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed been si should I 24a. Was an 24b. Were autopsy findings available Was an autopsy performed? prior to completion of cause of death? has page 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital Other: 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5  $\square$  Pending 1 Yes 2 No М Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00047398

State Registrar

10

Room 246

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street

32. Registrar'e Sigrature

orleans

DOUGLAS

MAC

2128

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $P^{M}$ 2010 05 9:50 March CLARA K. MINAHAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery 15310 Pine Orchard Drive #10 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 - M 2 X F Hours (Month, Day, Year) 03/31/1924 Country Director 85 578**-**46-7092 Usual Residence of Decedent lid be filed within 72 hours after death with the Maryland Mental Hyglene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 Yes 2 □ No Silver Spring MD Montgomery 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20906 United States 15310 Pine Orchard Drive #10 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Yes. Give 3 😾 Widowed 4 🗆 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Medical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clara Solomon Charles Katter permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumationes. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15310 Pine Orchard Drive #1C Silver Spring, MD Paula Minahan / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 X Removal from State 3/11/2010 4 ☐ Donation 5 ☐ Other (Specify) National Crematory Falls Church, VA Signature of Funeral Service Lice to e Melissa Greenhur 22. Name and Address Haward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, Maryland 20852 M01597 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Years Congestive Heart Failure Sequentially list conditions, Examine Due to jor as a consequence of it any leading to immedi cause. Enter Underlying executed Cause (Disease or linjury that initiated events and burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) Pregnant at time of death Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Renal Failure 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia autopsy page performed' 1 ☐ Yes 2 🛣 No 1 Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work?
1 Yes 2 No 1 X Natural 5 Pending nours after death.
neral Director: Aft
d filled in by the fur Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completed filled Medical 👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D34740 March 6, 2010

State Registrar

DHMH 17 Rev 7/2009

18109 Prince Philip Drive Suite 200 Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Robert P. Fields,

31. Date filed (Month, Day, Year)

09232

	•	For State Registrar	State of Maryla		ertifica			-	Reg. No.		
Physici	an	1. Decedent's Name (First, Middle, Last)  Melvin Randolph	Mardres, S	Sr.				2. Date of De. Month March	Day	010 Year	3. Time of Death 12:50 a M
/Medio Examir		4a. Facility Name (If not institution, give st			4b. City	, Town, or	Location of Death			County of Death	J
Exami		Gladys Spellman Specia:	lty Hospital &	Nursin	9	Cheve	rly			rince Geo	J
Funeral Director		370-22-3701	7. Age (in yrs	: last birtho	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month Da April	23, 1	9. Birthi	place (State or Foreigntry)
yland		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town o	r Location						10d. Inside City Limit
8a-f	cto	Maryland Prince	George's	15	Hyatt		.e				1 ☐ Yes 2 🐼 N
th with th	al Director	10e. Street and Number 2204 Calvert Str	eet		1	ip Code 0783			10g. Citiz USA	en of What Cou	ntry?
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiane. Item 27 ie marked other than "natural", or items 23s or 28s-f show other treumstic event, the Madical Exemplar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces?  1. XYes 2 No If Yes, Give Year or Dates: 194.	u.s. 2-45	I3. Was Dec If Yes, sp 1 ☐ Yes		ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Ameri Black, White, Specify: Whi	etc.
ithin 72 ho 16. nan "natur nan "natur	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  Todaya to a part of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the c									
t be filed water that the other the count, the	Be	17. Father's Name (First, Middle, Last) Otis Randolph Mar	dres		Accou	ntant	18. Mother's Nam Hazel H	e (First, Middle, ortense			vernment
nd 2 should lith and Me 27 ie mark r treumetid	2	19a. Informant's Name/Relationship (Type Mae Sue Mardres/W					and Number or Rui				
		20a. Method of Disposition  1 St Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	cemetery,	sposition (Na crematory or erans	other plac	I I I CI L	Ch 12, 010		ation - City or T	own, State
permit. Page Department of Important: if eny injury or once.		21. Signature of Funeral Service License	202		22. Name Fra 500 U	and Address ncis niver	s of Facility J. Collingsity Sity Blv	ns Fune d. W.,	ral H Silve	iome Inder Sprin	g, MD 209
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the de cause on each line.	ath. Do not	enter the mo	ode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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/Medical Examiner	Н	resulting in death)	Due to (or as a conse								
	آو ا	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Acute Rena Due to (or as a conse								
uted d ansit	E L	cause. Enter Underlying Cause (Disease or injury that initiated events	Pneumonia								
icate be executed physicien and s tha burial-transit	edical Examin	resulting in death) Last	Due to (or as a conse	equence of)							
ath certif attending for use e	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death	3 Ectopic 5 Other (:		,		2	3d. Date of deliv	ery Day Year
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The law require ete hes been sig paga 2 should b	Completed							24a. Was auto perfo		24b. Were aut prior to co death? 1 \( \text{Yes}	opsy findings availal ompletion of cause of
Physician: The this certificate hural director, paga	Be	25. Was case referred to medical examiner?	ospital:			. Oth	26. Place of Dea				
ਰ ਦੋ ਫ਼	on: To	1 ☐ Yes 2 ☐ No ☐ 1111  27. Manner of Death 12☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tim	ie of	28c. Injun Wor	y at k?	ome 5 Resi 28d. Describe		Other (Special occurred	(y)
or Attendated or Attendated Director; in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm	, street, facto		Yes 2 □No	28f. Location ( City or To			al Route Number,
To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: complately filled in by the	Medical C	29a. Certifier 1 Certifying Phys	cian: To the best of my ker: On the basis of examinand manner stated.	nowledge, on and/o	leath occurre or investigation	d at the tir	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
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		30 Name and address of person who con Opine II A. Cumber	noleted cause of death (It	100E	Print) Hospi			everly,	MD :	20785	
Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	1	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 James Charles Mandes Month March 4:15 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Chevy Chase 4c. County of Death Montgomery 8101 Connecticut Ave. Apt. S402 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 86 Days (Month, Day, Year) 04/27/1923 579-16-5681 1 X M 2 □ F Washington, Director DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If tien 27 is an and Mertall Hygiene. Important: If tien 27 is an andred other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Chevy Chase 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 8101 Connecticut Avenue Apt. S402 20815 12. Was Decedent Ever in U.S. Armed Forces? 1944-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give 1 Never Married 2 Married þ 1946 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Doctor Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne)
Zoi Christopoulos 2 Charles James Mandes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 02445Zoe Billman / Daughter 29 Colbourne Crescent Brookline, Massachusetts 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemet 03/12/2010 Silver Spring, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Congestive Heart Failure disease or condition Years Medical resulting in death) Due to (or as a consequence of): **Examiner** 20 Years Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Besecuted Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 1 ☐ Yes 2 L 9 ☐ Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus the Hospital or Attending Physician: The law requires 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Cerebrovascular Disease Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 X No 1 ☐ Yes 2 ☐ No ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) ပ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending work' 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Wyne Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

of certifia

Daniel J. Esposito MD

29b. Signature and title

D23783 MD

5530 Wisconsin Ave. #1400 Chevy Chase, MD 20815

29d. Date signed (Month, Day, Year)

03/09/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Ethel Berry McGee 2010 March Medical g 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing Home Pocomoke City Worcester . Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X Min. Month, Day Year 1910 Virginia **Director** 100 219-14-4461 Jan. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d, Inside City Limits 1 X Yes 2 No Worcester Pocomoke City 10e. Street and Numbe Of. Zip Code 10g. Citizen of What Country? Funeral 1006 Market Street 21851 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed 3 XWidowed 4 Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Henry Berry Mary Elizabeth Brimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lou Ella Henderson (daughter) 1408 Princess anne Lane, Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot . Page 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nelsons Cemetery 3/10/2010 Pocomoke City, MD 21. Signature of Funera THOTTOWAY Funeral Home, Professional Association 107 Vine St.. Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician disease or condition resulting in death) Medical o (or as a conseque) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conseque as the burial-trans t and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2 🖎 No ဂ္ 1 Tyes Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature of death (Item 23a) (Type Print) 30. Name and address of person 9 BA3 31. Date filed (Month, Day, Year) State Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KRISTEL V. MITCHELL March 1 6:45AM 2010 Medical 4a. Facility Name (if not institution, 4c. County of Death Examiner 4b. City, Town, or Location of Death If Under 1 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Davs Hours 9/1/1967 42 MARYLAND Director 233-21-1850 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d, Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21601 USA 704 LOMAX STREET 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event. the Medical Examin 1 Never Married 2 M Married 21215-0036 1 Yes 2 No Specify: WHITE If Yes. Give 3 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 MRI/RADIOLOGY SUPERVISOR HEALTH CARE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ RONALD WOLF JOYCE MCLEOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
704 LOMAX STREET. EASTON, MD 21601 19a. Informant's Name/Relationship (Type, Print) DENNIS M. MITCHELL/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 3/9/2010 CHESAPEAKE CREMATION STEVENSVILLE, MD 21. Signature duneral Service Licen FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD Part 1. Enter the disease, or complications that caused the death. Do not el shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metasta disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Quarto for es e ponsacuanda oficause. Enter Underlying signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director; After this certificate has leted filled in by the funeral director, page 2? autopsy performed 2 No 1 Yes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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MAR 0 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ Thong Hanh Nguyen March 4. 7:35 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral (Month, Day, Y Year) 193<u>9</u> Vietnam 586-40-8101 1 🕱 M 2 🗆 F Days Hours Min. 70 Director Usual Residence of Decedent show 10a. State 10b. County illed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No 28a-f Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 900 University Blvd., West 20901 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1  $\square$  Never Married 2  $\bigstar$  Married Completed by ☐ Yes 2 🙀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Asian Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Import/Export Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doan Thi Le permit. Page 1 and 2 should be: Department of Health and Ments Important: If item 27 is marked any injury or other traumatic ev once. ည Ta Ba Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 University Blvd., West, Silver Spring, MD 20901 Tonie Nga Thi Bui Nguyen/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park March 2018 4 Donation 5 Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licenses 27 Yan C14sdrs of Collylins Funeral Home 500 University Blvd. W., Silver Spring, MD 2090 23a. Part 1. Let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death less than Physician/ Acute Ischemic Cerebrovascular Accident 1 disease or condition Medical resulting in death) month Due to (or as a consequence of) Examiner more than 10 Severe Atherosclerotic Disease of Brain Sequentially list conditions years Examine Due to (or as a consequence on if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent precnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day Tyes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Hyperlipidemia, Asthma, Diabetes Mellitus 23e. Did tobacco use contribute to the cause of death? þ 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 🔀 No 1 Yes 2 No Yes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital 1 Tes ၉ 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of ë 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending Certificat 2 🗌 No 1 Tes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number filled in by after Direc determined within 24 hours a To the Funeral D Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

completed

0

3

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 08

30. Name and address of person who completed base of death (Item 23a) (Type, Print)

Charu Maheshwary, MD 1500 Forest Glen Road, Silver Spring, MD 20910

MD

Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D006868

2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dennis J. O'Connor, Jr.  $\mathbf{p}^{\mathsf{M}}$ 2010 3:19 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing Home Berlin Worcester Social Security Number Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 □ F Hours 78 5/26/1931 212-30-9826 Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Worcester Ocean City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13800 L. North Ocean Rd. 21842 USA 12, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 💢 Yes 2 □ No If Yes, Give O'Connor, Dennis J. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dennis J. O'Connor, Sr. Mary Perry 19a. Informant's Name/Relationship (Type, Print)
, Sister-in-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Hamilton 7897 East Riverside Dr., Pasadena, MD 21122 .aw 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗋 Burial 2 💢 Cremation 3 🗋 Removal from State 3/15/2010 Cape Henlopen Crem. Frankford, DE 4 Donation 5 Other (Specify) Signature of Fu Burbage Funeral Home 22. Name and Address of Facility 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or e caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) ending physician and use as the burial-transi law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown signed by the a 2 No 1 Yes 2 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' r Attending Physician: The this certificate 1 ☐ Yes 2 ☐ No After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural work? 1 ☐ Yes 2 ☐ No 5 Pending death. 2 Accident
3 Suicide Investigation nours after death neral Director: A I filled in by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R 135131 March 10, 2010

E. J. 10+||
State
Registrar

DHMH 17 Rev 7/2009

parke

9715 Healthway Dr, Berlin, MD

21811

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pennie Savage,

MAR 11

31. Date filed (Month, Day, Year)

CRNP

Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03/09 4 2010 Year Physician/ Margaret Mary Payne 5:30 p M Medical 4b. City, Town, or Location of Death Huntingtown 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Calvert. 5831 Carol Court 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🛣 F Days Hours 502-09-0394 (M97/73794/ Yes)17 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Huntingtown 1 ☐ Yes 2 🎦 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5831 Carol Court 20639 Funeral U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black White, etc Page 1 and 2 should be filed within 72 hours after d ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or i p 1 Never Married 2 Married ☐ Yes 2**x x**No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Counsel AFL-Cio Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Garvin Raymond Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5831 Carol Court, Huntingtown, MD 20639 Margaret Payne/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Lee Crematory 03/12/2010 Clinton, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Lee Funeral Home Calvert, 8125 Southern Md Blvd., Owings, MD 20736 Lisa M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line CHRONIC OBSTRUCTIVE PULMONARY Immediate Cause (Final disease or condition Onset and Death DISEASE Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir and -transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 ding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ DIABETES MELLITUS Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending hours after death.

neral Director: Aft
d filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital of within 24 hours a To the Funeral D completed filled is Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number munsh D000 1942 T

Jew 5

State Registrar

DHMH 17 Rev 7/2009

32. Registrar Signature

130 HOSPITAL RD PRINCE FREDERICK

MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

HENDER MUNSHI

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Vear Donaldson Peters March 1957 Frances Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth
(Month, Day, Year)
April 30,1927 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday, Funeral 1 M 2 K F Months Days Hours 215-20-3445 **Director** 82 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Maryland Montgomery Kensington 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral traumatic event, the Medical Examiner must 3333 University Blvd W 20895 United States "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 😾 Widowed 4 🗌 Divorced Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than "1 Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Elwood Donaldson Olive William Irene Beaver and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3333 University Blvd W. #203 Kensington, MD 20895 Cynthia D. Peters/daughter injury or other Baltimore, If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 3/12/2010 Woodbine, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 anyi urnita M00957 Momas 23a. Part \Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death days Immediate Cause (Final Physician/ Multilobar Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and s the burial-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical use as F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year Other (specify) Pregnant at time of death signed by the a 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes 2 g 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical of Vital To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 😾 No 1 XInpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Division I hours after death. uneral Director: Aft ed filled in by the fur 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a the Funeral C Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 3-11-10 e and address of person who completed cause of death (Item 23a) (Type, Print) Shahryar Davari, M.D. 10110 Molecular Drive, Suite 206 Rockville, MD 20850

DHMH 17 Rev 7/2009

**State** Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MICHAEL ALLAN PARSONT 00:12AM MARCH 2010 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Rockville Montgomery Shady Grove Adventist Hospital 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 5. Social Security Numbe 573–40–6435 9. Birthplace (State or Foreign 1 XM 2 - F Days Hours 75 New York **Director** 1934 Usual Residence of Decedent show 10a. State with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg 1 ₹ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 221 Booth Street #110 Funeral 20878 United States death v 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No 6MO
If Yes, Give 1969
Year or Date Reserves Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. College (1-4 or 5+) **5+** Elementary/Seconday (0-12) U.S. Government Scientist Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Abraham Parsont Sally Savadkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
221 Booth Street, Gaithersburg, MD 20878 Mina Parsont/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Georgetown Whitersity Medical Center 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 21. Signatura of Funeral Service /M00969 utarco (tend 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ MYOCARDIAL INFARCTION disease or condition resulting in death) MINUTES Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami -tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death been signed by the s should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? hours after death.

neral Director: After this certificate I
d filled in by the funeral director, pag 1 Yes 2 X No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes 1 Inpatient 2 XER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar DEBORAH J. SHERRILL MD 9901 MEDICAL CENTER DRIVE ROCKVILLE

31. Date filed (Month, Day, Year)

NAR 11 2010

Length B. Specks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

)3697

2010

20850

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Year Physician/ Leon Parker Payne рМ March 8 9:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing Home Pocomoke City Worcester Social Security Number 8. Date of Birth
(Month, Day, Year, 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Days Hours Min. Maryland 1 X M 2 🗆 F Director 218-20-2721 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No MD <u>|Worcester</u> Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2104 Bypass Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. g 1 Never Married 2X Married 1X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced white WWII Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales & Delivery Oil Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brinkman Payne Leona Mae Pruitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Payne (wife) 2104 Bypass Road, Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Reth Eden
Tiloman Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/11/2010 Pocomoke City, MD 22. Name and Address of Facility Holloway Funeral Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes Be ( 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? 2 X No Hospital: Other: မှ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State Medical 29a. Certifier 1 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and time of certifier 29d. Date signed (Month, Day, Year) 3-8-2010

BAHI

Box 68760

P.O.

Division of Vital

Registrar

31. Date filed (Month, Day, Year) MAR 11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

			Please	e Type or Prii amend item State of M	<b>nt in B</b> n 19a aryland					All Co vt d Menta	pies al Hyg	Are Le	egible.	0021.2
			Registrar  1. Decedent's Name (First, Middle, L	201)		Cei	rtificat	e ot L	Jeath	T 2 Dat	R e of Deat	eg. No.	UIU	3. Time of Death
	Physici /Media		Jacqueline Kay	,						Mo	nth	10 Day	2010	1:06 P M
	Examir	ner	4a. Facility Name (If not institution, g	,	)		,		Location of D	eath		4c. County of Death		
	Formeral		Atlantic Genera  5. Social Security Number 6.		ne (In vrs la	ast birthday)		erlin 1 Year	If Under 24	Hrs. 8 Dat	e of Birth	Wo	rceste	r hplace (State or Foreign
	Funeral Director		197-34-0435	1 ☐ M 2 ဩ F	66	Yrs.	Months	Days		7/2	e of Birth onth, Day, 24/19	Year) 943	Co	untry) PA
9	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
13:06	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and it ential Hygiene. Important; If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	żo	MD Worce	ster		erlin								1 □Yes 2 🛛 No
17	or 28	Funeral Director	10e. Street and Number				10f. Zip				1	0g. Citizer	of What Co	untry?
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1-10	fter de ritem iner n	Fun	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2X Married</li></ul>	12. Was Decedent Armed Forces? 1			Was Deced f Yes, spec	lent of His cify Cubar	spanic Origin n, Mexican, P	? (Specify Ye uerto Rican, e	s or No- etc.)	14.	Race - Ame Black, White	
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ya ya	ould b	2	Earl Newcomer							Cathe				
Maryland	d 2 sh Ith and 17 is m traum		19a. Informant's Name/Relationship  John M. Peterso	husband	ı	İ	•	•	nd Number o					Zip Code)
24 Te,	s 1 an of Hea item 2 other	0.03	20a. Method of Disposition		20b. Pla	ace of Dispo emetery, cren				Date			ion - City or	Town, State
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DOB. 7/24 Baltimore,	ermit. Separti mporti ny Inji		21. Signatule of Funeral Service Lic	englee					s of Facility				ral Ho	me
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	/Medical		disease or condition resulting in death)	a. Due to (or as			46.00		a now					
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0435	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (bries	a oursequi	enes ut):								
34- ( 60,	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):								
7-3	cate be ohysici the bu	dical	•	d										
197 0x 6	certification of the second	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	псу		0.5000013				220	. Date of deli	ivon
·沃 ···	ires that the death certificate signed by the attending phys if be detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic p Other (sp					230	Month	Day Year
% O.	at the d by th etache	Phys	9 Unknown	9 Unknown	4 .4 .						- Distant			45-2
ds,	Physician: The law requires that the death certificate this certificate has been signed by the attending phyrat director, page 2 should be detached for use as the	þ	Part II. Other significant conditions	contributing to death b	ut not resur	ting in the ur	ideriying ca	ause givei	n in Part I.	230				the cause of death?  obably 4X Unknown
Vital Records	w requir s been s should	Completed								248	a. Was a	n 2	24b. Were au	topsy findings available
13. 18.	The la ate ha	mo:			-					_	autops perforr Yes 2	y ned?	prior to o death?	completion of cause of 2 □ No
ita ita	cian: ertifica	Be C	25. Was case referred to medical examiner?							Death (Check			12,00	2 2 110
35	Physi rthis c ral dire	5.	1 ☐ Yes 2 XNo  27. Manner of Death	Hospital: 1 Inpatie		R/Outpatien		A Other	4 LI IVUI SII	ng Home 5		ence 6 D	<del></del>	cify)
C O	Attending r death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y, Year)	Injury	м	Work?	es 2 □ No	280. De	Scribe no	w injury or	curred	
Division	r Atte ter dea irector	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	∠8e. Place of Injection	ury - At hon c. (Specify)	ne, farm, stre	eet, factory,	office		28f. Loc	ation (St	reet and N n, State)	lumber or Ru	ıral Route Number,
20	pital o		29a, Certifier 1X Certifying F	Noveleine To the best	* f === 1 to ==	I. de a de att		- 4 Ab - 47		1			1	
4	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 %	Medical		Physician: To the best aminer: On the basis o and manner sta	of examinati	on and/or inv	estigation,	in my op	inion, death o	occurred at th	e time, d	ause(s) ar ate and pla	ace, and due	to the cause(s)
	To the within To the comple	Me	29b. Signature and little of certifier				29c	. License	number		2	9d. Date s	igned (Month	n, Day, Year)
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Į	ET 10		30. Name and address of person who Joseph A. Gras			,	,		-14-L	LIGIT MAT	010	1		
	Sta	te	31. Date filed (Month, Day, Year)	so, MD 100					diiSDU	iry, ML	7 218	SUI		
	Registr	ar	MAR I I	. 2010 Ken	wh	B. 19	park	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** g 85:5 Ruth G. Reed March 6, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Calvert Calvert Memorial Hospital Prince Frederick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Director 86 March 9, 1923 MD 219-10-6742 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at 1 ☐Yes 2 No Director MD Calvert Prince Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 264 Fairground Road 20678 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3XWidowed 4 ☐ Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, In a Mones. Elementary/Secondary (0-12) College (1-4or 5+) 9 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Rice Josie Contee ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Reed - daughter 11349 Tomahawk Trail, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope UM Church Cemetery! March 13, 2010 | Sunderland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Sewell Funeral Home, P.A. Gladen a. 1451 Dares Beach Rd., Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE ENAL CHRONIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 I Unknown 9 Unknown 23e. Did tobacco use contribate to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1ABETES MELLITUS 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy 1 □ Yes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 🔲 Inpatient 2 NER/Outpatient 3 □ DOA Certification: To 27. M vin of Death 1 Natural funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29b. Signature and title of certifier

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anway MunShi 130 HuS Prior RO

31. Date filed (Month, Day, Year)

32. Registrays Signature

AR - 8 2010 Charles of A

300 Prince Frederick

20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month 2010 Hilda L. Rinaldi 8:35a M Mar. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rising Sun Ceci1 Calvert Manor Healthcare Center Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours July 28 1 □ M 2 💢 F 82 Yrs. **Director** 219-28-4970 PA Usual Residence of Decedent 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Rising Sun 1 🗌 Yes 2 💢 No Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21911 1881 Telegraph Rd. USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 XMarried Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No Specify. Specify: White Completed 3 Widowed 4 Divorced or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 7 Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Charles Grove Catherine Bowersox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Doris A. Lentz/ daughter 8505 East Canyon Estates Circle Gold Canyon, AZ85118 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 3/13/2010 cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) West Nottingham Cemetery Colora, MD Funeral Service Licens 22. Name and Address of Facility Foard Funeral S. Queen St. Ri Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one cruim one crui Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LIN disease or condition Medical resulting in death) Due to (or as a cons r uence of). Examiner Sequentially list conditions, if any, leading to immediate course Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed illied in by the funeral director, page 2 should be detached for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Live Sirth Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 2 No Yes 2 N 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pendina work?
1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one d title of certifie 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stephen Roles Month 2010 March 5, 6:30 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** July 9, 1928 1 🖾 M 2 🗆 F Months Days Min. 562-54-9975 Country) Ireland Yrs. **Director** 81 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2X No Maryland Montgomery Silver Spring ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 706 Dartmouth Avenue 20910 Ireland Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. , or þ 1 Never Married 2 km Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hyglene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Contractor</u> Construction other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ments Important: If item 27 is marked any injury or other three gards. ဥ James Roles Margaret Halpin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 19a. Informant's Name/Relationship (Type, Print) Dolores E. Gutierrez-Roles/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 20a. Method of Disposition 20c. Location - City or Town, State March 12 2010 1 Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis Address Collyins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Vrter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as consequence of): Examiner 02 51 S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death ed by the a 1 ☐ Yes 2*C Unknown Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: Other: 2 WNo 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending

Box 68760 P.O. Records, **Division of Vital** the Hospital or Attending s after death.

Certificate: 1 🗌 Yes 2 🗌 No ☐ Accident☐ Suicide Investigation the 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, pleted filled in by determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Registrar's Signature State 2010 Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G902 4/16/2010 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:00 pM Victoria P. Rinaldi 2010 March Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Mooth, Day, Year)
April 17, 1922 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F Months 87 Director 579-14-4654 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 U.S.A. 4709 Great Oak Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. and Mental Hygiene. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bruno Kotulski Mary Kwiecinska 19a. Informant's Name/Relationship (Type, Print) Dauahter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 5101 River Road, #1405, Bethesda, Maryland 20816 Patricia Victoria Rinaldi, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 03/12/2010 permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 03/13/2010 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Sevial I cense 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death ed by the a detached f Yes 2 X No g Unknown 9 Unknown Division of Vital Records, P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s performed eral Director; After this certificate I filled in by the funeral director, page 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:  $_4$   $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospice 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Gity or Town, State) determined Medical 🗝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 8, 2010 MD60634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph, 1160 Varnum Street, #021, Washington, DC 20017 MD, State Registrar

### Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Orelia Yvonne Smith 22;44pmM 4,2010 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Hospital Prince George's Cheverly If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 579 – 52 – 9897 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 69 Va. Yrs Director 01/24/41 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23s or 28s-1 show the Medical Examinar must be notified at Prince George's X☐Yes 2☐No Md Directo Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 USA 2900 Mercy Lane filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: þ ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglent important: if item 27 is marked other tha any injury or other treumatic event, that once. Secretary 2years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ollie Moore Nannie Wylie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Imeh Smith Daughter 6317 Longfellow St Riverdale Md 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington 03/12/10 Adelphi, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Snead Funeral Home & Cremation 5732 Georgia Ave NW Washington, DC 77 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · ARTERIOSCIEROTE CARDIOVASCILAR DISEASE **Physician** 4 RAUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physiclan/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 BNo Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure Ventilator Depardent 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed Cenebral Infraction Vegetative State Renal failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Wellitus Peruphenal Vascular Disease 1 Yes 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Yes 2€ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide To the Hospital or Atte within 24 hours after de.
To the Funeral Diracto completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0001852 MARCY 5 ZOX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensivy ad Hyattsville MA 2078 au ADE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 08 2010 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ebecca onem	lan	1- For State Registrar		ate of Death	and Mental	, ,	2010 g. No.	09243		
Physici ledical Exam		Oecedent's Name (First, Middle, Last)     Rebecca Lauren Sherman				2. Date of Death Month March 4, 2	Day Year	3. Time of Death 1620 hrs		
		4a. Facility Name (if not institution, give street and number)  Suburban Hospital		4b. City, Tow Betheso	n, or Location of D		4c. County of Death			
Funeral		5. Social Security Number 6. Sex 7. Age (	(In yrs, last birt	hday) If Under 1	Year If Under 24		h(MM/DD/YYYY) 9. Birt			
Director	3	217-19-5506 1_M 2_\$\frac{1}{2}\$	26	Yrs. Months	Days Hours	Min. Dec. 1	L6, 1983 Foreig	untry) Maryland		
any		Usual Residence of Decedent  10a. State 10b. County 11	0c. City, Town	or Location				10d. Inside City Limits		
Aaryland 28a-f show 1 at once.	tor	Maryland Montgomery	Ga	aithersbur				1 Yes 2 X No		
th the Maryland 23a or 28a-f sho notified at once.	Director	10e Street and Number 20509 Farcroft Lane		10f. Zip Co 2 088		10	ng. Citizen of What Cour	ntry?		
ith with tems 23	neral	11. Marital Status  1 Never Married 2 X Married Armed Forces?	_		of Hispanic Origin? Cuban, Mexican, Pu	( Specify Yes or No- erto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,		
fter dea	by Fun	1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Year or Dates:	No	1 Yes 2 X	No specify:		Specify: Whi	te		
hours afte natural", Examiner	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Busines during most of working life. DO NOT use retired)									
036 ithin 72 ne. r than "	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+	<i>'</i>	omemaker			Own Home			
Baltimore, MD 21215-0036  Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene.  Important: I filed Ty is marked other than "natural", or items 23a or 28a-fshinjury or other traumatic event, the Medical Examiner must be notified at once	e C	17. Father's Name (First, Middle, Last) David Sherman	*			ame (First, Middle, M				
212 nould be id Menta is mark tic even	To B	19a. Informant's Name/Relationship (Type, Print )	1	- '			ber, City or Town, State,			
, MC and 2 sh cealth an tem 27 traums		David Sherman/Father  20a. Method of Disposition		20509 Farc of Disposition (Name of		Date Date	sburg, MD 2			
more Pages 1 ent of H nt: If i		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	,	ory or other place) Souls Ceme	tery	March 22, 2010	Germantow	n, Maryland		
Saltin Sermit. Departm mporta		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc.								
Physician		23a. Part. Enter the disease, or complications that caused th failure. List only one cause on each line.	e death. Do no					Approximate Interval Between Onset and		
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Contact Gunshot  Due to (or as a consequence)		Head				Death		
		Sequentially list conditions, b.	derice or).							
	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	uence of):							
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8760, tificate be ing physici as the bun	ın/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome 1 Live birth	of pregnancy 2	Fetal death	3 Ectopic pre	gnancy	23d. Date of delivery Month D	ay Year		
Box 6876 death certifical he attending ph	Physician/l	1 Yes 2 No 9 V Unknown 9 Unknown	ne of death 5	Other (Specify)	)					
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Division pital or Attendit ours after death. teral Director: A	1 Natural   5 Pending   Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natural   5 Natu									
Spi fil		4 Homicide  29a. Certifier 1 Certifying Physician: To the best of my k			ne, date and place,					
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated.  29b. Signature and title of certifier	nation and/or in		cense number	ed at the time, date a	and place, and due to the 29d Date signed (Mon			
$\nu$	-	Con as Halon	_		O.C.M.E.		March 5, 2010	, ==;,,		
		30. Name and address of person who completed cause of dea		Penn Street, Ba	Itimore MD 24	l				
<u></u>	tate	Carol Allan, MD Assistant Medical Examil 31. Date filed Month, Dev Year 2010 32. Registrar's	0.	8,000	idifiole, MD 21	201				
Regis	trar	MAR UO ZUIU Jeneur	B. 19	all.						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death D**2**010 Physician/ Shapiro Carmen March 5, 6:04 ам Karin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9804 Conestoga Way Montgomery Potomac Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Days (Month, Day, Year) 1950 1 🗆 M 2 🔀 F Hours Yrs Director 220-58-5867 59 Germany Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Potomac 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9804 Conestoga Way USA 20854 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc Completed by XX Never Married 2 Married Yes 2 KNo Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Money Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Erwen Shapiro Margot T. Trutschel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margot T. Quinn/Mother 9804 Conestoga Way, Potomac, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven Cemetery 1 🛂 Burial 2 🗌 Cremation 3 🔲 Removal from State March 12 Silver Spring, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Juneral Service License Inc. Spring, MD 20901 Mehand L Dates 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Disease years disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Diabetes Mellitus 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events Morbid Obesity 30 years the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy , page performed? Yes 2 No 2  $\square$  No certificate 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗆 No

Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760 Division of Vital 24 hours a Funeral L

completed filled in by Medical 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D52509 March 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 Rockledge Drive, Bethesda, MD 20817 MD Sue Danzinger Kanter, 0 8 Registrar's Signature

Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar Accident

Suicide

4 Homicide

29a. Certifier

(Check

Investigation 6 Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Dale I Selby Medical February 2010 7:30 A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 **X**) F Hours Min. Director 285-03-1625 21/1917 Washington DC Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 Leisure World Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: 3 X Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Rosenthal Bessie Weitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blanken / son-in-law S. Leisure World Blvd. 531-B 20906 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grdn. 3/7/2010 Falls Church 21. Signature of Funeral Servi 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike, Rockville MD 20852 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Urosepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Dian to for es e nonsequenne on and -transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the burial attending physician Physician/Medical Box 68760 use as 1 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 Year Month Day Pregnant at time of death 5 Other (specify) Yes 2 🛚 No signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 To the Hospital or Attending Physician: The law requires Dementia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title Prtific 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

State

Ave.

Russell

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Steven Dolinsky MD

31. Date filed (Month, Day, Year)

D 20148

Gaithersberg MD 20879

February 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				Department of Health and		•
			1 - For State Of Maryland / Registrar	Certificate of Death		2010 00252
	11.5		Registrar  1. Decedent's Name (First, Middle, Last)	Commodite of Beatiff	2. Date of Death	3. Time of Death
4	Physici		Guy Edward Shaffer		Month March 7,	Day Year 2:25 p. M
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death
N.			Oakland Nursing & Rehab. Center	0ak1and		Garrett
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I	Months Dave Hours Mir		9. Birthplace (State or Foreign Country)
k	Director		234-58-0764 73  Usual Residence of Decedent	Yrs.	Aug. 20,	1936 WV
	land ow t			wn or Location		10d. Inside City Limits
	Mary -f sh fied a	ţ	WV Preston Eg1	on		1 ☐ Yes 2 🌠 No
	n the	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	th wit 23a o ist be		1118 Maple Spring Highway	26716	Ţ	Jnited States
	filed within 72 hours after death with the Maryland Hygiene. vither than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte ; or it amin	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖔 No If Yes, Give 3 ☐ Widowed 4 ☐ Woivorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify:
21215-0036	hours tural' al Ex	d b		Sa. Decedent's Usual Occupation	14	White 6b. Kind of Business/Industry
5	in 72 n "na fedic	olet	(Specify only highest grade completed)	(Give kind of work done during most of w life. DO NOT use retired)	orking	S. Kild of Business/industry
212	d with giene r tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Coal Miner		Coa1
힏	be filed Ital Hyg Id othe event,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Na	ame (First, Middle, Ma	aiden Surname)
<u>ylaı</u>	should b and Ments marked umatic e	2	Herman Woodrow Shaffer	Gertr	ude Paulin	e Sell
Maryland	2 sho	1 3		9b. Mailing Address (Street and Number or I		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.			1118 Maple Spring Hi		
Jor	Pages lent of H nt; If ite		▶ Burial 2 □ Cremation 3 □ Hemoval from State	1 - 7	11/2010	Oc. Location - City or Town, State
Baltimore,	it. Partiment		4 □ Donation 5 □ Other (Specify) Garre  21. Signature of Funeral Service Licensee	tt County Memorial G	Gardens	Oakland, MD
Ba	permit. Departi Imports any Inj once.		Wather was Alexite	David A. Burdock 21 N. Second St.	Funeral F	Home, P.A.
Н	ام رس	1	23a. Part1. Enter the disease, or complications that baused the death. D shock, or heart failure. List only one cause of each line.			
G.	Physician	d q	Immediate Cause (Final	Proprietar	- Ps.	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence)	e of):	00011	0000
	Examiner		Sequentially list conditions b.	evel COPD		year(
	Do to	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of).	_	
	ecute and -trans	хаш	that initiated events resulting in death) Last C	phenoconio:		year!
760,	ate be executed nysician and he burial-transit	cal E	But to (or as a consequence	o oij.		3
687	death certificate be attending physic		d			
Box	nding use a	M/u	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
-	death e atte d for	icia	in the past 12 months?  1 Veg. 2 No. 4 Pregnant at time of death			Month Day Year
P.0	that the de ned by the s detached f	Physician/Medi	9 ☐ Unknown		1	
	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	by F	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		acco use contribute to the cause of death?
ord	requir	ted			1. Yes	2 No 3 Probably 4 Unknown
ec	law lasb	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ᇤ	: The cate I	Con			performe 1☐ Yes 2√	ed? death? No 1 Yes 2 No
Vital Records,	Physiclan; r this certifica ral director, I	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor	eath (Check only one)	
o	Phys r this ral di	. To	1 Inpatient 2 EH/C	Dutpatient 3 DOA Outlet 4 Nursing  Dutpatient 28c. Injury at	Home 5 Residen	ce 6 □Other (Specify)
Division or	Attending ir death. ector: After by the fune	tion	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury Work?  M 1 ☐ Yes 2 ☐ No		,,,
Visi	Atter	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office		eet and Number or Rural Route Number,
	tal or s afte al Dir ed in	Certification:	Building, etc. (Operary)		City or Town,	States
	To the Hospital or Attending Physiclan: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de		29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch	ge, death occurred at the time, date and pla and/or investigation, in my opinion, death or	ce, and due to the cau	use(s) and manner as stated. te and place, and due to the cause(s)
	To the lewithin 2. To the I complet	Medical	one) and manner stated.	29c. License number		
	M T S		29b. Signature and title of certifier	D 65 3 1		d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a			311.0
		6	Dr. Thomas G. Johnson, 311 N. 4		MD 21550	
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	1.41		
	- Part 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	•	pepartmer Certificat			, ,	iene	10	092	53
	Physicia		Decedent's Name (First, Middle,	Last) Judit		SILVE			2. Date of Deat	h	Year	3. Time of 12:40	
 1	Medic Examin		4a. Facility Name (if not institution, Carriage Hill [				Town, or	Location of Death	,	4c. County	of Death	ــــــــــــــــــــــــــــــــــــــ	
	Funeral Director				(In yrs. last birth			If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birth	place (State of	r Foreign
	<b>A</b> .	۲	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside Cit	ty Limits
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	with the s	Funeral Director	10e. Street and Number 5215 W. Cedar	Lane		10f. Zij	208	14		Og. Citizen of V United			
036	be filed within 72 hours after death with the Maryland ental Hygiene. Wed other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at.	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 Å N If Yes, Give Year or Dates.	er in U.S.	13. Was Dece If Yes, spe 1 Yes		spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		k, White. א <b>h</b> ז	can Indian, etc. te	
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212	within rgiene. rer thau t, the N	Cor	Elementary/Seconday (0-12)	College (1-4 or 5+	.)	Homemak				Own I	lome		
and		To Be	17. Father's Name (First, Middle, L. <b>Ernst Ba</b>	•					ne (First, Middle, N el Selign		∍)		
Mary	2 should th and M 27 is mar traumat		19a. Informant's Name/Relationsh Tina Silverman	ip (Type, Print)	19b. 22	Mailing Addres	s (Street a	nd Number or Rur On Ave.,	al Route Number, #102, Si	Gity or Town S	State, Zip	Code) MD	20910
Baltimore,	Page 1 and nent of Heal int: If item : iry or other		20a. Method of Disposition  1 X Burial 2 Cremation 4 Donation 5 Other (S	3 X Removal from State pecify)	20b. Place of cemeter Adas I	Disposition (Naty, crematory or C	me of other place	gation 0	Pit 2010 emetery	20c. Location Washi			
Balti	permit, Page 1: Department of I Important: If its any injury or of		21. Si mature of Funeral Shrvice I.	ERROR - TOTAL	8001	Torveren	nskys	HEBYEW F	uneral H		nc 2	20012	
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. ,	mysician/ Medical Examiner		disease or condition resulting in death)	a. End Stac Due to (or as a			se				1	weeks	
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Box 687	or Attending Physician: The law requires that the death certificate be executed after death. Differ death and after this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 K/2 No 9   Unknown	23c. If yes, outcome o  1  Live Birth 2 4  Pregnant at 9  Unknown	Petal death	3		y			ite of deliv		<b>⁄e</b> ar
s, P.O.	ires that th signed by d be detac	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Diabetes Mellitus, Hypertension, Dysphagia, Failure  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.										
Division of Vital Records, P.O. Box	The law requ cate has been page 2 shoul	Completed by	to Thrive, De	pression					24a. Was a autops perfon	sy m <b>y</b> d?	prior to co death?	ppsy findings a empletion of c	available ause of
<u>a</u>	sician: The certificate irector, pag	Be Co	25. Was case referred to medical examiner?				26. Pla	ace of Death (Chec		2' No	1 🖵 Yes	2 ∐ No	
<u> </u>	Physic this ce	은	1 ☐ Yes 2 💢 No  27. Manner of Death	Hospital:  1  Inpaties  28a. Date of injury		tpatient 3 D	OA Othe	4 LX Nursing H	ome 5 Reside			y)	
o uo	tending leath. tor: After the fune	Certificate:	1 X Natural 5 □ Pendin 2 □ Accident Investig 3 □ Suicide 6 □ Could I	g (Month, Day,	Year) ir	njury M	work'	Yes 2 No	Zod. Describe IR	iw injury occurr	ea		
Divis	the Hospital or Attending Phys hin 24 hours after death. the Funeral Director: After this mpleted filled in by the funeral di		4 ☐ Homicide determ	ined 28e. Place of Injur building, etc.	(Specify)				28f. Location (St City or Town	ı, State)			per,
	To the Hospital of within 24 hours af To the Funeral Di completed filled in	Medical	(Check 2   Medical E	Physician: To the best of n xaminer: On the basis of ex- Nurse Practioner: To the b	amination and/o	r investigation, in	my opinio	n, death occurred a	at the time, date an	d place, and du	e to the ca	ause(s) and ma	nner stated.
	with Some			bundar.			c. License D 53	3367	ļ	9d. Date signe March 9	, 20	10	
			30. Name and address of person v Shyamsundar Raj			Type Print) gia Ave	nue,	Suite 1	l7, Silv	er Spri	ng,	MD 209	902
	Sta Registra		31. Date filed (Month, Day, Year)	2010 2. Registrar	's Signature	backed.							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 8, Day 2010 Year 1135 A Irvin Silverman 4a. Facility Name (If not institution, give street and number, 4c. County of Death Montgomery General Hospital 01ney Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Days 07/20/1939 213-56-4545 Hours 1 X M 2 □ F 70 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9507 Sweet Grass Ridge 21046 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Elevator Operator US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Silverman Sally Zamansky 19a. Informant's Name/Relationship (Type. Print) Barry Rappaport - Brother-in-law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9507 Sweet Grass Ridge Columbia MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) Beth Sholom Congregation Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/10/10 Capitol Heights, MD 21. Signature of Funeral S 22. Name and Address of Facility Chapels Inc 1170 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Modical Engineer must be notified at once.

Baltimore, Maryland 21215-0036

fication: To Be Completed by Dhusisian/Madical Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death)	a. Contio yu me	uence of):				
Sequentially list conditions, if any, each yet inneclat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1975 19 53	encyratic Co	nce T			months.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregn 1  Live birth 2 Fete 4  Pregnant at time of	al death 3 Ectopi	ic pregnancy (specify)		23d. Date of deliv	very Day Year
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlyin	g cause given in Part I.			the cause of death?
		·		24a. Was an autopsy performed2 1 □ Yes 2	prior to co	opsy findings available ompletion of cause of
25. Was case referred to medical			26. Place of D	eath (Check only one)		
examiner? 1 Yes 2XNo	Hospital: Impatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Spec	ifv)
27. Manner of Death  1 ★ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fact fy)	tory, office	28f. Location (Street a City or Town, Sta	and Number or Rui te)	ral Route Number,
29a. Certifier (Check only one) Certifying Ph	ysiclan: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occur ation and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
29b. Signature and title of certifier	М	D	29c. License number		ate signed (Month	, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Grunt

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ND

Year)

(Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 05, 2010 Physician/ Michelle Schaffer Seltzer 11:18pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Rockville Montaomeru Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country), Maryland Days 1 M 2 X F Months Hours Min. Director 220-42-4268 66 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Tes 2 No Maruland Montgomery Rockville 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 5821 Edson Lane, Apt. #304 20852 U.S.A. items ; 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or <u>\$</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 X Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "ns any injury or other traumatic event, the No. 21 once. (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Library Associate Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Schaffer Edith Weiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jerri S.</u> Falk - Daughter 3494 Constellation Drive, Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 03/12/2010 Brentwood, Maryland 21. Sign (ure /f Funeral Ser ice Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00209 <u>11800 New Hampshire Ave., Silver Spring,</u> MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death One Year Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Colorectal Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 1 Yes 2 4 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 X No certificate has 1 Yes tor: After this certification the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No å 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 D Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 2 Accider 5 Pending injury Accident Investigation 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 29d. Date signed (Month, Day, Year) lun mini March 6, 2010 s of person who completed cause of death (Item 23a) (Type, Print) Joseph J. Puthumana, MD, 201 E. University Parkway, Baltimore, Maryland 21218 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 11:45 P Madeline Seifert 2010 /Medical March 8 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 911 Snure Road Silver Spring Montgomery 5. Social Security Number 6 Sev Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗓 F Director 054-18-8181 86 NY 8/13/1923 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evanciae rust be notified at 1XYes 2 No Director MD Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 911 Snure Road 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Yes. Give چ و If Yes, Give Year or Dates: 3 N Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Drug Store Clerk marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental I Be Mollie Hurwitz Bernard Shayne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an 11103 Easecrest Dr. Silver Spring MD 20902 Paula Seifert / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If Ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gdns. 03/10/2010 01ney, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville, MD 20852 MO1477 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Chronic Obstructive Lung Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure Examiner be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Year Dav 5 ☐ Other (specify) signed by the a P.O. 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed: 2X No certificate 1 Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 🕅 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No nours after death neral Director: / filled in by the f 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in the Funeral C completely filled in the Funeral C completely filled in the Funeral C completely filled in the funeral C completely filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in the filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

D 47928

March 9, 2010

MI

32. Registrar's Signature

Lila Bahadori, MD 10301 Georgia Ave. #304 Silver Spring MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 MARTHA 04 SCLICHTER 2010  $\mathbf{P}^{\mathsf{M}}$ JANE 4:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4751 SAILORS RETREAT RD TALBOT OXFORD Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 Months Days Hours Min JULY 10, 175-03-1411 1914 PENNSYLVANIA Director 95 Usual Residence of Decedent show 10a, State death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f 1 Yes 2X No MD TALBOT OXFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 4751 SAILORS RETREAT ROAD 21654 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 ▼ Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 RETAIL SALES ASSOCIATE RETAIL Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWARD KIMPLE MARY DIMLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY MAYHEW/DAUGHTER 4751 SAILORS RETREAT ROAD, OXFORD, MD 21654 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or ot 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State CHESAPEAKE CREMATION 3/8/2010 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. MERCERO 5 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 3 4 KS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) မ After this o 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No To the Hospitallor Attending within 24 hours feer death.

To the Funeral Director Afte completed filled in by the fune. 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 3 R124198

Registrar

State

30. Name and address of person who completed cause of

MAR 0 8 2010

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Md21601

death (Item 23a) (Type, Print)

Commen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March **Physician** 2010 TRAN VAN THANH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Regional Hospita George's _aurel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct.13, 1936 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1√ M 2□ F Vietnam 586-18-4736 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Beltsville 0a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If we death Evant and by nother traumatic event, If we death Maryland Prince George's 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20705 United States 4826 Naples Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Asian Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) EG&G Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOC THI NGUYEN TIN VAN TRAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 4826 Naples Avenue Beltsville, Maryland 20705 TAM T. TRAN -son 20c. Location - City or Town, State Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 3/8/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarving Licens Donald V. Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardia Acute **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Arteriosclerotio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760 P.0. Records, Division of Vital

attending physician and for use as the burial-transit law requires that the death certificate be executed signed by the a d be detached f icate has been sig certificate has funeral director, this After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by the ompletely

28a-f show

Baltimore, Maryland 21215-0036

4 Homicide 29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Day, Year) 29c. License number 22966

2010 MD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas H. Burguieres, MD

7300 Van Dusen Rd. Regional Hospital Emergency

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Catharine Holsinger Taber Physician/ March 7, Day 2010 Year 5:37 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min May 16, 1920 Pennsylvania 161-18-7018 89 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Examiner must be 23a Funeral 3701 International Drive, #635 20906 USA items ; within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Deceden. Armed Forces? 1 ☐ Yes 2 🙀 No Black, White, etc. 0 1 Never Married 2 Married þ Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed and Mental Hygiene.

is marked other than "natural raumatic event, the M-dical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virgil Holsinger Bessie Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Joseph John Taber, Jr./Son 11306 Mapleview Drive, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Durial 2 X Cremation 3 Removal from State March 2010 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA ²Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury mE Examine burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Sctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) the ( Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death?
1 Yes 2 No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 🗷 No Int 501 2 Accident Investigation 2009 Jan 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Flactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 [ only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D38457 March 8, 2010

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nakul Goyal, MD 3801 International Drive, #211, Silver Spring, MD 20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>010</u> Physician/ Month 9:19 PM 8 March Winkler Stanley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Month, Day, Yes
July 22, New York Year) 1 X M 2 - F Director Yrs. 90 087-16-4564 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🖵 No 28a-f Bethesda Maryland Montgomery ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 20817 6413 Earlham Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black White etc. "natural", or Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5± Government Scientist Be At Page 1 and 2 should be arrivent of Health and Mental Hy arrivent of Health and Marked of arrafic eve 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Winkler Horn Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6413 Earlham Drive Bethesda, Maryland 20817 Rosetta Winkler/wife permit. Page 1 and Department of Heall Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 3/9/2010 Woodbine, Maryland Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Licenses Thomas M00957 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Severe Aortic Stenosis disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) physician and the burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown ins ceruncate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congestive Heart Failure autopsy performe 1 Yes 2 No Renal Failure 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State)

completed filled in by the funeral 24 hours after deat Funeral Director: To the within 2

Par

<u>...</u>

0

30. Name and address of person who comple 12 8600 bld Natasha Haag State

29b. Signature and title

3

🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print)

enera

Georgetown Road Bethesda, Maryland 20814 Registrar's Signature

Registrar

Medical

29a. Certifier (Check

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ Stephanie Renee Welch Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death WMHS Regional Medical Center Allegany Cumberland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. Sept. 10, 1965 1 M 2 D F Hours Maryland Director 218-64-7514 Usual Residence of Deceden 28a-f show 10a. State 10h County 10c. City, Town or Location Examiner must be notified at Director MD Garrett Grantsville 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21536 12358 National Pike USA "natural", or items Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manufacturing Laborer any injury or other traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Sandra Goehringer Thomas Durst, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Bridgette K. Welch/Daughter 12358 National Pike, Grantsville, MD 21536 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🛭 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 2010 Davidsville, PA Country Side Crematory March 11, Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. eumac P.O. Box 275, Grantsville, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or help failure. List only one cause on each line. Immediate Cause (Final Physician/ infective disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ned by the atter Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Accident 24b. Were autopsy findings available prior to completion of cause of death? CEREBRO Vascular 24a. Was an has autopsy performe Storge ENd Disease 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Priving Within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

3. Time of Death

1 Yes 2 No

Approximate Interval Between Onset and Death

Day

Year

М

State Registrar 30. Name and add

DHMH 17 Rev 7/2009

illowb Rook

ess of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DOO18216

Rd.

Cumberland mD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jed Allen Wood Month Medical 1:06AN Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS-Regional Medical Center Cumberland Allegany Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 1 X M 2 🗆 F 8. Date of Birth 9. Birthplace (State or Foreign Director 216-90-5132 Hours Min. May 27ay ⁷1964 Marvland Usual Residence of Deceden or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. at 10b. County **Funeral Director** 10c. City, Town or Location traumatic event, the Medical Examiner must be notified 10d. Inside City Limits MD Garrett Swanton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23a 293 Ardsley Farm Rd. 21561 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black, White, etc. 3 Divorced 4 Divorced If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) is marked other Laborer Labor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٥ Charles Robert Wood Irene Loretta Solomon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Tracy Lee Wood/Wife 293 Ardsley Farm Rd., Swanton, MD 21561 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Blooming Rose Cem. March 10, 2010 Friendsville, MD Signa re of Fumeral Service 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a conse the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day 9 Unknown Year ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? filled in by the funeral director, page 2 should be Division of Vital Records, 2 No 3 Probably 4 Unknown has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate I autopsy perform 2 No Be ( 1 L Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospita ပ္ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 1 Matural 28d. Describe how injury occurred (Month, Day, Year) Pending work? Investigation 6 Could not be Accident 2 No Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, thin 24 hours a City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within To the 29b. Signature and title of certifier

State Registrar

MAR - 9 2010

WMHS-Regional Medical Center, Cumberland, 32 Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

s Signature

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2010 March 2, Naomi Brooks Wright 7:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arcola Health and Rehabilitation Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🖾 F 116-32-4432 90 Director March 24,1919 Virginia Usual Residence of Decedent Maryland la or 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Silver Spring Maryland | Montgomery the 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Mydical Evantine must be any ange. 20910 901 Arcola Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Yes Give 2 3 ☑ Widowed 4 ☐ Divorced Year or Dates: American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Associate Professor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Eugene Brooks Ollie Wheeler ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1937 Lyttonsville Road, Silver Spring, Maryland 20910 Ardrea Burrell/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery | 03/08/2010 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses 7400 Georgia Avenue N.W. Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☑ Unknown 2 □ No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 ☐Yes 2 ☑No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1No Other: 1 ☐ Yes 4 Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760

State Registrar

DHMH 17 Rev 1/200

3

Medical

29a. Certifier

31. Date fi

29b. Signature and title of certifi-

30. Name and address of person who complete

**ORIGINAL** 

cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

1111 Spring St # 214 Silver Spring

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 19a per FH G902 4/1/10 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9. Day 2010 Year March 13:15 M Ruth Weinreb Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X Months Days Jan. 18 ^Y°f'923 NewYork **Director** Yrs 87 092-14-6100 Usual Residence of Decedent 28a-f shov 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Bethesda MD Montgomery 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 20814 5413 York Lane "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 3 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes Give Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hyglene. Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ida Brod Jack Kramer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Jack Weinreb/Husband 5413 York Lane, Bethesda, Maryland 20914 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😾 Burial 2 🗆 Cremation 3 🛣 Removal from State 4 Donation 5 Other (Specify) 3/14/2010 Pinelawn, New York Wellwood Cemetery Syvice Licensee Tamie 21. Signature of Eu 22. Name and Address of Friward Sagel Funeral Direction, Inc. ie Arthurs M01163 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Cardiac Arrest Due to (or as a consequence of) Physician/Medical Box 68760 Hypertension IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No Day Pregnant at time of death ed by the a g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Diabetes II Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia Jas autopsy performed? Yes 2 X No page Acute Renal Failure certificate 1 Yes 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tyes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fo 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 D53691 March 10, 2010

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of per-

31. Date filed (Month)

Ajay Reddy

2010

MD 3200 Tower Oaks Blvd. Suite#110, Rockville, Maryland 20850

on who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#8perFH, 3/11/10, PMW, McCo Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Wormley 2010 4:45A /Medical Α. Feb. 25 Katie 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chevy Chase Montogomery Manor Care 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 1 □ M 2 😿 F 92 155-03-0283 Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1★ Yes 2 No Director Yeadon PA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 739 Bullock Avenue Funeral 19050 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) years Medical <u>Nurse Pediatric</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louella Andrews Jasper Hadley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 739 Bullock Ave. Yeadon, PA. 19050 Joseph Wormley/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) 3/3/2010 Beverly, NJ. Beverly Veterns 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4000 Haverford Ave. Morse Funeral Home Philadelphia, PA19104 CC#0278 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WKS Immediate Cause (Final 5 disease or condition resulting in death) Arrhythmia Due to (or as a consequence of): 5 Wks Mycardial Infarction Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Hypertension Years Due to (or as a consequence of): Diabetes Mellitus Physician/Medical Years IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

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Division or Vital Records,

Hospital or Attending Physician:

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hyglic Important: If Item 27 Is marked other 1 any injury or other traumatic event, tt

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Chronic Renal Failure

24a. Was an autopsy performed? Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tes 2 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

Ramam

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mall

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Tuli, MD Darnestown Rd. Suite 202 Gaithersburg, MD 20878 31. Date filed (Month, Day, Year) 2. Registrar's Signature MAR 11 2010

10810

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 22 Physician/ рМ 2010 1:05 Blanche M. Adams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 612 Hollow Road Ellicott City 8. Date of Birth (Month, Day, Year) NOV • 7 , 1920 9. Birthplace (State or Foreign Country) New York 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 M 2 XF Months Days Hours 89 Director 050-12-8645 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Director Baltimore Ellicott City 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 612 Hollow Road 21043 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. à 1 Never Married 2 Married ☐ Yes 2 🛛 No 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working alth and Mental Hygiene.

127 is marked other than "in traumatic event, the Med Baltimore City life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Health Department Registered Nurse 4 Be Baltimore. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Kevovitz Meyer Macoff Bessie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21229 item 27 James Adams, Son 402 Drury Lane other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland 3/24/2010 Metro Crematory, Inc. 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Cremation Society of Maryland, Inc. Signature of Funeral Service Licensee Alice Iser 299 Frederick ROad Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between nset and Death Immediate Cause (Final disease or condition Brain Physician/ Medical resulting in death) (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? Month Day g 🗌 Unknown P.O. II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by mollitus 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending s after death. 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer and address of person who completed eath (Item 23a) (Type_Print) N Charles Atree, Ball more

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) MAR 26 20

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Registrar's Sgnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 630 A M MARCH 24 2010 Beverly Ann Beck /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPITAI AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/16/1937 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🛛 F 72 Maryland 214-44-1771 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the "walcal Exercinal must be rediffied at 1 ☐ Yes 2 ☐ No Director Lansdowne Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21227 United States 3158 Ryerson Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TXNo Specify Specify: White δ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If them 27 is marked other the any injury or other traumatic event. Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Doodie Joseph Spurrier ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. James A. Bennett, Jr. (Grandson) 3158 Ryerson Circle, Lansdowne, Maryland 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 03/29/2010 Baltimore, Maryland Loudon Park Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21 Signature of Funeral Service Licen ee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HOUKS **Physician** CAKDIOGENIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CORDNAKY RENAL DISEASE page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DISEMSE autopsy performed? 1 □ Yes 2 △No 1 ☐ Yes 2 X No of Vital After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XX No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death e Funeral Director; filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MARCH 24 2010 Kvelim Gutneaner MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 MD BALTIMORE 31. Date filed (Month, Day, Year)

MAR 2 EVELIN GATHECHA 900 SCATON AUE 32. Registrar's Signature State

DHMH 17 Rev 1/2001

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Henry F. Bert, S	r.	State of Maryland / Department of Health and Men		ible.					
		1- For State Certificate of Death	, 0	g. No. 2010	09268				
Physicia	an/	Decedent's Name (First, Middle,Last)	Date of Death     Month		3. Time of Death				
Medical Exami	ner	Henry 1: Bere, Br.	March 21,	2010	1837 hrs				
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Good Samaritan Hospital  Baltimore	of Death	4c. County of Death	1				
Funeral			er 24Hrs. 8. Date of Birtl	h(MM/DD/YYYY) 9. Bir	thplace (State or				
Director		214-98-5076 1XM 2 F 45 Yrs. Months Days Hours	Min. 12/09/	1964 Foreig	in untry)MD				
		Usual Residence of Decedent	12/09/	1704	TID				
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
land -f sho	to	MD N/A Baltimore			1 X Yes 2 No				
e Mary or 28a	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?				
ith the 23a c		3405 The Alameda 21218  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Control of Marital Status 21218	gin2 / Specify Ves or No.	U.S.A.	can Indian, Black,				
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215-0036 be filed within 7 mtal Hygiene. rked other than ent, the Medica	Completed	12 th Transportation Supe	's Name (First, Middle, M	Juvenile Jugarden Sugname)	ustice				
215 e file tal Hy nt, th	BeC		aret J. Jon						
21; ould b d Men s marl	70 E	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Num			, Zip Code)				
MD od 2 shoulth and in 27 is aumat		Henry R. Bert 3405 The Alameda B							
ore, of Hea If iter		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory or other place)	Date	20c. Location - City or	Town, State				
Page ment or oth		4 Donation 5 Other Specify: Parkwood		Parkville,	MD				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show, injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West							
Physician	$\dashv$	Jerome Thompson (per DVR) 4300 Wabash Ave	e., Baltimor	e, MD 2121. st. shock, or heart	Approximate Interval				
/Medical		failure. List only one cause on each line.	,	.,,	Between Onset and Death				
Examiner		Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):							
		Sequentially list conditions, b.							
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, P.O. Box 68760, ires that the death certificate but signed by the attending physic be detached for use as the but	ian/Medical	CON 1840 december 4 conservation that	pregnancy	23d. Date of delivery  Month E	ay Year				
OX 6 ath ce	0	Pregnant at time of death 5 Other (Specify)							
b. B.	Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	int I. 23e. Did tob	acco use contribute to	the cause of death?				
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tal Records, ician: The law requirent certificate has been sector, page 2 should		25. Was case referred to medical 26.Place of Death (		No 1 ✓ Ye	s 2 No				
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ospita hours neral		4 Homicide determined (Specify)							
Divis To the Hospital or A within 24 hours after To the Funeral Dire	Medical	29a Certifier   Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla (Check only one)							
To with To com	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number	Т	29d. Date signed (Mor	th, Day, Year)				
		hy hi, no		March 22, 2010					
	ŀ	30. Name and address of person who completed cause of death (Item 23a)							
		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01						
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature							

DHMH 17 Rev 1/2001 OCME 2006

Amend #5, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per Fh 9901 3/29/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year Rose Basiliko March 22 8:30 p. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Health Care Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth _(Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Hours Washington, 219<del>-49</del> -6283 Director 87 Oct. Usual Residence of Decedent 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo DC District of Columbia 1 → Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3713 Legation St., N.W. 20015 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ş 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 filed within 72 hours after 1 Yes 2 XNo White Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Secretary Legal 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Helen Chaichonos George Kalivretenos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Davis (daughter) 2531 Creek Dr. Harker Heights, Texas 76548 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State March 2010 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on the control of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause o or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Dil to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death), leat Due to (or as a consequence of) Exami Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown P Month Pregnant at time of death the signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural work?
1 Yes 2 No 5 Pending ie Hospital or Attendii n 24 hours after death. ie Funeral Director: A Accident M Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License numbe signed (Month, 29d. Date 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayed Muhamed Elsayyad, M.D. 10110 Molecular Dr. #206, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State MAR 26 2010 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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IIIICO EIIICICOII		For State Certificate of Death Reg. No.
Physicia	n/	egistrar 1. Decedent's Name (First, Middle,Last)  James Butts 2. Date of Death Month Day Year March 20, 2010 3. Time of Death 2100 hrs
ledical Examir		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death
		Washington County Hospital
Funeral Director	4	97-88-7635 1 M 2 F 26 Yrs. Months Days Hours Min. 01/03/1984 Foreign MI MO
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
<u>*</u> *	٦	MD Washington Hagerstown 1 Tyes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show maric event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10820 Downsville Pike 10f. Zip Code 21740 USA
n with		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
er deatl		3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2 No specify: White Specify:
urs aft tural"	d b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
5 72 hor nn "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)
within giene.	티	10 COOK RESTURANT  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Tapp
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Bec	Ricky Don Butts   Jamie <del>Patp</del>
21; hould b nd Men is mar	2	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 6048 01
a a a a	5.01	Jamie Butts/Mother 2525 E. 32nd St. Apt. E124 Joplin, MI  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Removal from State  20c. Removal from State  20c. Removal from State  20c. Removal from State  20c. Removal from State  20c. Removal from State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'njury or other traumatic event, the Medical		Chosaneake Crem   2010   Deitsville, HD
Baltimo permit. Page: Department o Important:		4 Donation 5 Other Specify: Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility (AFA Step en D. Lohrmann P.A. 8717 Green Pastures Dr. Balto, MD 21286
De Per July	111	Rebecce Hockey MD 21286
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Bothot enter the mode of dying, sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach as sach a
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Combined drug (hydromorphone & methadone) intoxication  Due to (or as a consequence of):
		Sequentially list conditions, b.
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated
ed sit	Exar	events resulting in death) Last Due to (or as a consequence or).
760, icate be executed physician and the burial - transit	Medical	X UNPENDED 23a,27,28a-f,perME G902 4/26/10 TT #9,18perFH,4/23/2010,WS,G902
760, cate be physici he buri		IF FEMALE: 23c. If yes, outcome of pregnancy
OX 687 eath certifics attending p	cian	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death 5 Other (Specify)  Other (Specify)
BOX e death the atte	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 29 Unknown 23e, Did tobacco use contribute to the cause of death?
that the d ned by the detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death / 1 Yes 2 No 3 Probably 4 Unknown
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cor e law re e has b	Completed	performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rec cian: The certificate rector, page		25. Was case referred to medical 26.Place of Death (Check only one)
Vita hysicia this ce	To Be	examiner?  1 V Yes 2 No  28 Date of Injury  28b, Time of Injury  28c, Injury at Work?  28d, Describe how injury occurred
n of Ading Phys.  After t	.: O	1 Natural 5 3 - " (Month, Day, Year)
isior Attend er death rector:	icati	2 Accident Investigation Fd 3/20/10 Fd 3:30 pm
Div Dital or surs after in illed in	Certification:	4 Homicide determined (Specify) ED Hagerstown, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To Witing	₩ We	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
		Theodore M. Kind TRy Mr. D. O.C.M.E. March 21, 2010
		30. Name and address of person who completed cause of dealth (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	tate	31. Date filed (Month, Day, Year)  ARR 26 2010  August Augusta
Regis		ORIGINAL
DHMH 17 Rev 1/	ZUU T	ONORAL

State of Maryland / Department of Health and Mental Hygiene 2 [] | [] Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 104UK M 7,010 Medical Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bult Mac ruman Millerta . Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex **Funeral** Days Min. Year 1947 1 ☐ M 2 💢 F July 23 Maryland 212-48-6592 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medic... Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford Maryland Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 21040 USA 1985 Brookside Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 N Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Federal Government Civilian Contractor should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Margaret Golladay Stephen Paul Bilka Department of Health and Important: If item 27 is m. any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Charles Drive Windsor, PA 17366 James Bratton, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 03/25/10 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service License Thomas Gregor 22. Name and Address of Facili Cremation Soci 299 Frederick Tety Of Maryland, Inc Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) I by the attending physician and stached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 Yes 2 g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only op and title of certifier Baltonye, Md. South 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WARD (021 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan 22 1 ✓ M 2 🗆 F Months Days Hours Min. Year 1932 Pennsylvania 206-26-2737 78 Yrs Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Anne Arundel Annapolis Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 **1**501 Broadneck Place Unit 101 USA death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1  $\times$  Yes 2  $\square$  No 1950 If Yes, Give 1954 Black, White, etc. "natural", or Completed by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Specify. 3 X Widowed 4 Divorced 1954 Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RCA Salesman Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Sarah Dunn Edward Henry Byrns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Byrns, Jr., Son 1615 Old Mill Bottom Run Annapolis, MD 21409 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 03/24/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee emation Society Of Maryland, 9 Frederick Road Baltimore, Thomas Gregor Inc. Maryland 21228 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between On et apa Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day 5 Other (specify) Year the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 🗌 Yes 2- No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autonsy performe certificate 1 Yes 2 No the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 | Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 | Certifying Nurse Practioner, for the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. ure and title of certif 21438

DHMH 17 Rev 7/2009

State

Registrar

N

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year MARVIN BRIDGEMAN 13:19 MARCH 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER 5. Social Security Numbe 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country)
 MD **Funeral** Months Days Hours 0571571929 Director 80 212-26-7522 Usual Residence of Decedent show 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 💢 No MD **CARROLI HAMPSTEAD** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3943 SHILOH AVENUE USA 21074 death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify: Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry e filed within all Hygiene.
Ther than "r.
t, the Me. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) **ACTUARY** INSURANCE 2 should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BRIDGEMAN HERBERT **EDITH** GOODMAN traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau SUSAN BREWER / DAUGHTER 3943 SHILOH AVENUE, HAMPSTEAD, MD 21074 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State OHEB SHALOM MEM. PARK 03/25/2010 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CORONARY disease or condition resulting in death) ARTERY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy this certificate Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 2 No 1 🗆 Yes Other မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P24346 MARCH 23, 2010

Registrar DHMH 17 Rev 7/2009

State

BALTIMORE, MD

2101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREENE

7. ar's Signature

22 31. Date filed (Month, Day, Year)

SOUTH

State Registrar ANOMLISTOWN

JOGINDER P. MEMTA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

PITAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 MARCH 12:58 AM ANGEL COSSIO Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOSEPH RITCHIE HOSPICE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 🖾 M 2 🗆 F Days Hours 07/04/1939 Director 70 PERU 230-31-3185 Usual Residence of Decedent show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 ☐ No VA ARLINGTON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4715 N. 15TH ST PERU 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or il edical Examine by 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 WHITE 1 X Yes 2 □ No Specify: PERUVIAN If Yes Give Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Rusiness Industry Elementary/Seconday (0-12) College (1-4 or 5+) other t UNK UNK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental H 27 is marked of traumatic ever ည UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Page 1 and 2 ROCIO FUENTES/NIECE 20118 SILVER CREEK TER., APT 106, ASHBURN, VA 20147 3altimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. ŏ 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/24/2010 HANOVER, MD Signature of Juneral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. <u> 2007-09 EASTERN AVE., BALTIMORE. MD</u> 21231 Part 1. Enter the disease of complications that caused shock, or heart failure. Let only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pancrectic Cancer netartares to liver and skine Physician/ 11.w disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death signed by the a g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 
No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been sis completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 No 1 Tes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hos Pic C Hospital 2 1 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

RAYMOND 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a. M HOZJIW .W

D0041476

6565 N CHARLES ST, SLITE 416, BALTIMORE

18/2010

03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22 pay Physician/ March _2010 Hobart Doy1e Cline 7:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) est <u>Virginia</u> Feb. 2, 1935 1 X M 2 D Months Days Hours Director 75 West 578-44-6317 Usual Residence of Decedent shov 10a. State 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director 1 ☐ Yes 2 🕅 No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6905 Niles Dr. 20707 United States death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 XMarried þ Maryland 21215-0036 within 72 hours after 1 Yes 2XXNo Specify: White If Yes, Give "natural", 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked of Cline Ransom Hobart Gene Mabel Suzanne other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 strength of Health a Mary Ann Cline / Wife 6905 Niles Dr., Laurel, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State ò permit. Page Department of Important: If any injury or Chesapeake Crematory : 3/26/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 20910 M0038Z 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Multilobar Pneumonia resulting in death) Medical Medical Examiner Due to (or as a consequence of) End-Stage Emphysema Sequentially list conditions. francisconding to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequency of requires that the death certificate be executed use as the burial-transit Acute Respiratory Failure signed by the attending physician and dedetached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Coronary Artery Disease, Peripheral Vascular Disease, 1 X Yes 2 No 3 Probably 4 Unknown been si Completed 24a. Was an 24b. Were autopsy findings available Cigarette Smoking cate has autopsy perform prior to completion of cause of performed? Yes 2 2 No 1 Yes 2 No this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 🗌 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 🔼 No ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

P.O. Box 68760 Records, Division of Vital or Attending Physician;

within 24 hours after death. To the Funeral Director: After completed filled in by the To the Hospital Medical

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

D 0065485

Barbara Supanich RSM. MD 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Supanich, RSM, MD; 1500 Forest Glen Rd., Silver Spring, MD 20910

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For	State of Marylar	nd / Departme	ent of Health and	Mental Hyg	giene	00077
		_	State Registrar		Certifica	ate of Death		Reg. No. 2010	09211
	Physicia Medic		1. Decedent's Name (First, Middle, La	ham Da	sei S		2. Date of Dea Month March	Day Year 2_4 20(0	3. Time of Death
	Examin		4a. Facility Name (if not institution, give			ty, Town, or Location of Death Bal howe City		4c. County of Death	
	Funeral		5. Social Security Number 6. S		last birthday) If Un	der 1 Year   If Under 24 Hrs.	8. Date of Birtl	h 9. Birth	place (State or Foreign
	Director		230-32-4254 Usual Residence of Decedent	1 □ M 2 1 F 83	Yrs. Month	ns Days Hours Min.	5 Month, Day	1926 Ulr	ginia
	and show	or	10a. State 10b. County	10c. Cit	ty, Town or Location			1	0d. Inside City Limits
5	filed within 72 hours after death with the Maryland al Hygiene. 4 other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	Funeral Director	ud Bait	). Ou	vings,	hills			1 🗌 Yes 2 🗷 📉
Davis	vith the 23a or st be r	eral [	3414 Ascar	ates 112	art 10f.	Zip Code		10g. Citizen of What Cour	ntry?
1	items	Fune	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
Mathe :15-0036	after or samir, or	d by	1 ☐ Never Married 2 ☐ Married 3 ♣ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates.		s 2 ho Specify:	o riioari, etc.)	Black, White,	etc.
Mathe 215-0036	hours natur dical E	olete	15. Decedent's I	Education	16a. Decedent's U	sual Occupation		16b. Kind of Business Inc	dustry
72	thin 72 ane. than " he Me	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO NOT	work done during most of wor use retired)	king	Hanle	
CLS Ind 2	iled within Il Hygiene. other tha rent, the N	Be	17. Father's Name (First, Middle, Last)		12718		ne (First, Middle, i	Maiden Surname)	
	should be fil and Mental is marked aumatic ev	욘	Milton Pa	rham		Clara	Jack	30n	
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Addr	ess (Street and Number or Ru	ral Route Number	City or Town, State, Zip C	Code)
	e 1 and 2 s of Health If item 27 or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3		Place of Disposition (f	lame of prother place)	Date	20c. Location - City or To	own, State
ting 5	permit. Page 1 Department of Important: If i any injury or c		4 Donation 5 Other (Spec	ify) Par	ham Family	1 Ccm. 4-	3-2010	Disputanta	la.
'ahent Baltim	Deparation of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con		21. Signature of Funeral Service Licer	Dundan	22. Name	and Address of acility	+ Fune	14 Service	1217
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	inplications that aused the dear	th. Do not enter the m	ode of dying, such as cardiac	or respiratory arr	110,100	Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition	a Sepsis					Onset and Death
1	Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):				,
	, ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	juence of):				
×	be executed sician and burial-transit	Examiner	Cause (Disease or itijury that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):				
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	rtificati ling ph e as th	/Mec	IF FEMALE:	200 16					
ox (	ath ce attend I for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	23c. If yes, outcome of pregnation 1 Live Birth 2 Fet 4 Pregnant at time of	al death 3 - Ectop	ic pregnancy (specify)		23d. Date of delive Month	ery Day Year
O. B	t the de by the tached	Phys	g Unknown	9 Unknown					
ر. ح.	requires that the death certifica been signed by the attending p should be detached for use as t	d by	Part II. Other significant conditions of Severe Miple vesse		,			obacco use contribute to the	
ord	v requi	olete					24a. Was a	an 24b. Were auto	osy findings available
Rec	ician: The law certificate has rector, page 2	Completed by					autop perfor 1  Yes	prior to co rmed? death? 2 No 1 Ves	mpletion of cause of
ta	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death (Che			
of V	g Phys er this eral dii	e: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of injury	ER/Outpatient 3   28b. Time of	DOA 4 Nursing F	T T	dence 6 Other (Specify ow injury occurred	)
on	eath. or: Aft	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Suicide 6 ☐ Could not		injury M	work? 1 Yes 2 No			
Division of Vital Records, P.O. Box 687	spital or Attending Physician: ours after death, eral Director. After this certific filled in by the funeral director,		4 Homicide determined			tory, office	28f. Location (S City or Tow	itreet and Number or Rural n, State)	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit	Medical	29a, Certifier 1 Certifying Phy (Check 2 Medical Exam	ysician: To the best of my know niner: On the basis of examination	vledge, death occured	at the time, date and place, a	I and due to the cau at the time date a	use(s) and manner as state	d.
1	o the l	Me	only one) 3 Certifying Nu 29b. Signature and title of certifier	rse Practioner: To the best of m	y knowledge, death or	curred at the time, date and pl	ace, and due to the	e cause(s) and manner as st 29d. Date signed (Month,	ated.
T	⊢ ≶ F ō		Dentra Ther	) MD		RES 000		Harch 24, 20	
	7		30. Name and address of person who	completed cause of death (Iten	n 23a) (Type, Print)		- 2		
	Stat		Cecilia Yshii - Tan 31. Date filed (Month; Day, Year)			ital of Baltim	of e		
	Stat Registra		MAR 2 6 20		1 1	,			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dickerson Month Day Year 1:00a. Medical 03 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death West Couton Avenue Bultimore Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 💥 🗆 F Hours 02 25 69 Director 38-32-5442 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified or 28a-f 1 Yes 2 □ No MD Baltimore NA 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 21229 3321 West Caton Ave U.S.A. items ; death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 72 hours after 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 ☐ No Specify: 3 Widowed 4 X Divorced Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within Caton Castle 9th grade Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Johnson Randolph Aldridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Melbourne Road, Baltimore, Md 21229 Shana Mc Iver-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or 4 Donation 5 Other (Specify) ling Memorial Park 3/30/2010 Woodlawn, Md 21. Sign turn of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave Baltimore Md 21215 23a. Part I. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) week Medical Due (or a la conseque of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury to (or as a consequence of) executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Month Day Pregnant at time of death 2 No Yes ed by the a detached f 9 Unknown 9 I IInknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Vasinlar page 2 s performed Yes 2 certificate 1 Yes 2 No 25. Was case referred to medica Division of Vital director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? death. 2 No Accident after death Director: A d in by the f investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after

To the Funeral Directory

completed filled in b City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar 30. Name and address of person who completed cause of

31. Date filed (Mont

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 22 2010 ar Suzanne Dunbar 7:45 Ам Genevieve Bon Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Nursing Home Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Days Hours July 3, 1924 231-36-0511 France Director 85 Usual Residence of Decedent Hygiene. other than "natural", or items 23a or 28a-f show ent, th∞ Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 9709 Leatherfern Terrace, Apt. A 20886 France 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Nidowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) filed within Laboratory Technician Medical Ith and Mental Hygien 27 is marked other the traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filk tment of Health and Mental tant: If item 27 is marked o ဂ George Victor Bon Marie Cherese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Beach Dunbar/Daughter 4146 Hamilton Street #4, San Diego, CA permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of March 25, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) All Souls Cemetery 2010 Germantown, Maryland Signature of Funeral Service Licens Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 a. Millia M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Interval Between 1 Onset and Death Immediate Cause (Final Physician/ Alzheimer's Dementia-Advanced disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live as Section 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 Live Birth 2 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 1 No death? certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 🗌 Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 X Natural completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred After t 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation s after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Cerifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D28656 March 22, 2010

DHMH 17 Rev 7/2009

State Registrar 15245 Shady Grove Road, Suite 130, Rockville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ravi Passi, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LOUIS FRAIOLI Physician/ MARCH 20°, 2018 1:10 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALTIMORE Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1X M 2 | F Months Days Hours 156-07-5130 90 Director PENNSYLVANTA Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director BALTIMORE MD RASPEBURG 1 🗆 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4413 PARKWOOD AVENUE 21206 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced Specify: WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) EXAMINER TEXTILES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GUISEPP FRAIOLI DOMENICA (VERICCHIA) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANNE BURNES/DAUGHTER 4413 PARKWOOD AVENUE BALTIMORE, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State HOLY REDEÉMER CÉM 4 Donation 5 Other (Specify) 3-24-10 BALTIMORE, MD 21. Signature of Fundamental arvive Licens 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linguithat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Year sate has been signed by the a page 2 should be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No eral Director; After this certificate I filled in by the funeral director, pagr 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Tes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and the of co

Date filed (Month, Day.

JACKIE JONES,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

6

2010

LOUIS FRAIOL

Registrar DHMH 17 Rev 7/2009

State

2300 DULANEY VALLEY RD.

3 Registrar's Signat

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hy	giene	
	-		Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death		Reg. No.	1 09281
	Physicia		Johanna Clara Flaim		2. Date of De Month	Day Year 23, 2010	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	March	4c. County of De	
			Kensington Park	Kensington		Montgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Bir	th lab	irthplace (State or Famian
7	Director		213-44-5480 1 □ M 2 🖾 F 86 Yrs.	IVIOITIIS Days Hours IVIIII.	August	12, Year) 12, 1924 Pen	insylvania
	nd how	ž	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation		-	10d. Inside City Limits
	aryla la-f s ified	ecto					1 🗆 Yes 2 🗓 No
	or 28	ρ	Maryland Montgomery Bethesda  10e. Street and Number	10f. Zip Code		10g. Citizen of What C	
	with s 23a ust b	Funeral Director	5919 Rolston Road	20817		United Sta	tes
	items items		11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Am	erican Indian,
36	after (	by	1 ☐ Never Married 2 ☒ Married Armed Forces? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No 1f Yes, Give	1 ☐ Yes 2X No Specify:	to nican, etc.)	Black, Whi	,
3	e filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Completed	3 U Widowed 4 U Divorced Year or Dates.				
Ç.	72 h an "na Medik	du	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	rking	16b. Kind of Business United State	
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פ	filed all Hyg	Be o	17. Father's Name (First, Middle, Last)		me (First, Middle,	, Maiden Surname)	
Maryland 21215-0036	ld be Menta arkec aric e	မ	Michael Saksa	Anna F	alatka		
Jar	should be file h and Mental 7 is marked of traumatic eve			ling Address (Street and Number or Ru			, ,
e o	and 2 Health			Rolston Road, Be	thesda,		
Baltimore,	ge 1 a		1 32 Delital 2 13 Oremetion o 13 Hemoval nom otate		ch 31,	20c. Location - City o	r Town, State
	iit. Pa artmer ortant njury		4 Donation 5 Other (Specify) Gate of He	aven Cemetery 20	10	Silver Spri	ng, Maryland
g Ra	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.		21. Signature of Funeral Service Oconsee // Right House // M01530 7	22 Name and Address of Facility Obert A. Pumphrey Fune 557 Wisconsin Avenue,	eral Home/ Bethesda,	Bethesda-Chev Maryland 208	y Chase, Inc. 814
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.				Approximate Interval Between
F	hysician/		Immediate Cause (Final disease or condition Myocardial Infar	ction			Onset and Death
	Medical Examiner		Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate b. Congestive Heart Due to (or as a consequence of):	Failure			
	red nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury Pulmonary Emboli	cm			
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200	tificat ng ph as th		IF FEMALE:				
D X	th cer ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3			23d. Date of d	*
POX.	e dea the a hed fe	Physician/M	1  Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		Month	Day Year
л. Э. :	nat th ed by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did t	obacco use contribute t	to the cause of death?
ູ່.	lires t sign Id be	d by			1 🗆	Yes 2 X No 3 🗆	Probably 4 🗆 Unknown
0	v requ	olete			24a. Was		utopsy findings available
Vital Records,	he lav te has age 2	Completed			auto	psy prior to ormed? death?	completion of cause of
	ian: I rtifica rtor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Che		2 A No 1 L Ye	es 2 No
5	nysic nis ce I direc	To E	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 X Nursing F	Home 5 Resi	dence 6 Other (Spe	cify)
ַ סַ	ing P	ate:	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	28c. Injury at work?		now injury occurred	
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DIVISION	affer affer I Direct d in by		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tov	Street and Number or Ri vn, State)	ural Route Number,
•	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred.	at the time date a	and place, and due to the	cause(s) and manner stated
:	ithin 2 or the or the or	Ĕ	only one) 3 Critiving Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	death occurred at the time, date and pla 29c. License number	ace, and due to th	ne cause(s) and manner a	s stated.
	- <i>s</i> ⊨ ŏ		1 Hy Wed day	D53691		29d. Date signed (Mon. March 24,	
	_		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
	8		Ajay Reddy, M.D. 3200 Tower Oaks Blv	d. #110, Rockvi11	e, Maryl	land 20852	
	Stat Registra		31. Date filed (Month, Day, Year)  NAR 2 6 2010  32. Registrar's Signature	6.0			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :25 P. M Veronika Antonia Fassler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Baltimore Washington Medical Center Glen Burnie Arundel 5. Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** March 25 1 - M 2 - F Months Days Hours Min. West Germany 212-36-5906 Director 1925 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 🗌 Yes 2 🔣 No Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 831 Ritchie Highway United States 21146 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give 1 ☐ Yes 2 🕅 No Specify: White 3 X Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Forwarding Company <u>Vice President</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be filed tment of Health and Mental Hi tant: If item 27 is marked ot permit. Page 1 and 2 should be fi Department of Heath and Mental Important: If item 27 is marked any injury or other traumatic ev once. Josefa Sterflinger Sebastian Schuerf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Strathorn Drive, Cary, North Carolina 27519 Diana Vogel/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 24, 2010 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nemmon disease or condition resulting in death) Medical Due to (or as a consequence ^rExaminer Whom Sequentially list conditions, Examine if a ry, leading to immediate cause. Enter Underlying Chiefo for as a nonsecular ce of: To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran and that initiated events Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ signe be c 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ιė 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier person who completed cause of 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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State of Maryland / Department of Health and Mental Hygiene	2010	09
State of Maryland / Department of Fleditif and Mental Flygiene	2010	0 2 6

ntae Gee		State of Maryland / Departme	ent of Health and Mental H te of Death	ygiene	2010	09283
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)	to or Boatin	Reg	g. No.	3. Time of Death
edical Exam			SEE	Month March 19,	Day Year 2010	0015 hrs
		Facility Name (if not institution, give street and number)     Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral		Social Security Number		. 8. Date of Birth	h(MM/DD/YYYY) 9. Birth	place (State or
Director		213089381 18M 20F 25	Yrs. Months Days Hours Min	104	-85 Foreign	
Å		Usual Residence of Decedent				
1 0w an		10a. State 10b. County 10c. City, Town o	TIMORE			10d. Inside City Limits  1 Yes 2 No
arylanc 8a-f sh at onc	cto	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Count	
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygieval land: Ifficen 27 is marked other than "matural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Director	3411 TERESA CT	21213		USA	,
th with	Funeral	11. Marjtal Status 1 Never Married 2 Married 2 Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto</li> </ol>		14. Race - Americ White, etc.	an Indian, Black,
er deat , or it.	Fur	Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	10001, 010.7		ACK
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MD d 2 sho lith and n 27 is			3411 TERESACT	BAUTO	MD. 21213	3
re, s 1 and f Heal If iten			Disposition (Name of cemetery, by or other place)		20c. Location - City or T	
Baltimore, permit. Pages 1 an Department of Hea Important: If iten niury or other tr.		4 Donation 5 Other Specify:			LANSDON	
Baltimore permit. Pages 1 Department of I Important: If injury or other		21. Signature of Funeral Service Licensee	22. Name and Address of Facility We			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac of	r respiratory arres	st, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Gunshot Wounds				Between Onset and Death
Ladilliloi		or condition resulting in death)  Due to (or as a consequence of):				
	ner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
cecuted n and - transit	a E	d.				
O, the exc sician burial -	edical	UNPENDED AMENDED				
876 tificate ng phy as the l	m/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregna	ncy	23d. Date of delivery  Month Da	y Year
Box 68760,  death certificate be excited attending physician of for use as the burial.	sician/Me	4 Pregnant at time of death	Other (Specify)			
O. B. Ithe de by the	Phy	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to the	e cause of death?
ires that the signed by	d by			1 Yes	2 No 3 Proba	bly 4 Unknown
ords v requi s been should	olete			24a. Was ar		psy findings available impletion of cause of
of Vital Records, of Physician: The law require ther this certificate has been sineral director, page 2 should be	Completed			perform 1 Yes 2	ned? death?	2 No
tal Recionary The certificate	Be (	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FB/Out	26.Place of Death (Check opatient 3 DOA Other Nursin	The second		
of VI ng Phys After this uneral di	: To	1 Yes 2 No 28a, Date of Injury 28b, Ti	patient 3 DOA Other 4 Nursin me of Injury 28c. Injury at Work?		Residence 6 Other:	
On Cending	ıtion	1 Natural 5 Pending Mar 18, 2010 2326		Subject shot		
Division ospital or Attendir hours after death. uneral Director: A	Certification:	Suicide Could not be	n, street, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rura	Route Number, City
D spital hours ineral y filled		4 V Homicide determined (Specify) Sidewalk		3241 Belair Ro	ad, Baltimore, MD	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only one) 2				
To To Con	Mec	29b. Signature and title of certifier	29c. License number		29d. Date signed (Monti	n, Day, Year)
		Whan Branell MD	O.C.M.E.		March 19, 2010	
		30. Name and address of person who completed cause of death (Item 23a)				
		Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year) 32. Registrar's Signature	111 Penn Street, Baltimore, MD	21201 —		
Regis	tate	ST. Date filed (Month, Day, Year)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20a, perfh g901 3/26/10 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:40 PM March 24, Year 201 Virginia D. Grubb Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 83 1 🗆 M 2 🔀 F Covity) Virginia Feb 25 Year) 1927 212-22-3822 Yrs. Director Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Directo Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Acorn Circle 21286 Apt. 101 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. f Health and Mental Hygiene. Item 27 is marked other than "natural", or i 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: 3 ₹ Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospitality Domestics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dewey Thomas Nannie Dinkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8717 Green Pastures Drive Towson, MD 21286 Lynda Ritter /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Mar 31 cemetery, crematory or other place)
Arlington National Cem. 1 X Burial 2 Cremation 3 Removal from State Arlington, Virginia 2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ EMPHUSEM disease or condition resulting in death) Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or finjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> ISCHEMIC CARDIO MYOPATKY Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate 2 🗆 No 1 Ves 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 XONo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completed fillediin by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Descritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning in my calculated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number **D64395** 29b. Signature and title of certifier MARCH 24,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N CHAPLES ST, 84 1784105 BALTIMORE, MS 21204 DANIENE DOBET-MAN, MO Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HAGGERTY, JR. JOSEPH DANIEL Physician/ Month MARCH 2010 45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE GILCHRIST HOSPICE CENTER TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 213-34-6989 72 Yrs. Director PENNSYLVANIA Usual Residence of Decedent 10b. County 10a. State filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director ROSEDALE MD BALTIMORE 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2038 FLINTSHIRE ROAD APT103 21237 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) PRODUCE MANAGER SUPERFRESH permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
FLOSSIE MAE (HICKS) ပ JOSEPH DANIEL HAGGERTY, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES A. HAGGERTY/WIFE 2038 FLINTSHIRE RD APT103 ROSEDALE, altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🛣 Cremation 3 🗆 Removal from State METRO 3-26-2010 CATONSVILLE, MD CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. S' hature of Fun al Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate interval Between Onset and Death Immediate Cause (Final Physician/ ecta disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the attending physician and thed for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day n signed by the at 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certificated filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: ျ 1 Yes hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Ø Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MAR 26 2010

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ST TONSON MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dana S Hartis 18:54 Medical March 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland niversity Baltimore, MD Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🛮 F 575-62-8847 Months Hours April 9, Director 48 Annapolis, Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Ellicott City Maryland Howard 1 ☐ Yes 2 1 No 10e. Street and Number 10f. Zip Code 21043 10g Citizen of What Country? United States Funeral 8444 Cotoneaster Court Apt. 2E of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc.
white Armed Forces?
1 ☐ Yes 2 XXIIIo ģ 1 Never Married 2 Married If Yes Give 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pharmaceuticals Representative Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Estelle Berti permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even Paul D. Slack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15 Summer Fields Court Lutherville, Maryland
21093 19a. Informant's Name/Relationship (Type, Print) Dr. David J. Hartig/ spouse 20a. Method of Disposition 20b. Place of Disposition (Name of March 27, 20c. Location - City or Town, State Evans Funeral Air Chapel – Bel Air 1 Burial 2 X Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.A. Peaceful Alternatives Funeral & Cremation Center, P.A. Timonium, Maryland 21093 2325 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Supsis Medical resulting in death) Due to (or as a consequence of): Examiner Cirrhosis 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 N To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica Be 25. Was case referred to medical сотретен filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital **1**0 1 🗌 Yes Other: 1 💆 Inpatient 2 □ ER/Outpatient 3 □ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) Rebucia Krochmal MD P24327 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) crochmal Kebuca 22 S. Gruni Baltimore MD 31. Date filed (Month, Day, Year) 32 registrar's Signature State MAR 26 2010 Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 287 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Loretta Hideko Hardison 10:35PM /Medical march 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Itosy tal Baltmore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 18, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F 1956 Massachusetts Days Min. Months Hours 214-66-0731 54 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 Yes 2 No Directo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 358 E. Belvedere Avenue 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 No à 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic evance. Harold Leroy Washington, Sr. Hideko Mori ဥ 19a. Informant's Name/Relationship (Type. Print)
Victoria Shizuko Washington /
Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 Queen Anne Avenue Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Arundel Crematory WARROWN 4 Donation 5 Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Ligensee Donaldson Funeral Home & Crematory P.A. 1411 Annapolis Road Odenton, MD 21113 23a Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): with multi organ /Medical Examiner Preynania Sequentially list conditions, if any leading to manufacte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami physician and the burial-trans Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy ormed? 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

MAR 26 2010

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Bernardo

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Raver Boylerard Byltzme

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Daniel Lee Hannibal State of Maryland / Department of Health and Mental Hygiene 010 09268 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day March 22, 2010 Medical Examiner 1600 hrs DANIEL LEE HANNIBAL 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 100 Keamey Drive Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country) Maryland Director 19,1980 219-98-9305 1X M 2 F 30 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
ant: If item 271s marked other than "natural", or items 23a or 28a-f sho ar other traumatic event, the Medical Examiner must be notified at once. Maryland Harford Forest Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2132 Poteet Road USA 21050 Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 2 X No Yes or Dates: 4 Divorced 1 Yes 2 No specify: Specify: White <u>δ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Chef Restaurant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) David Lee Hannibal Karen Lynn Slater 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD Jen April Hannibal 2132 Poteet Road, Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place 4 Donation 5 Other Specify: Christian Cem 3 - 27 - 10Joppa, Maryland injury or 21. Signature of Funeral Service License 22 Name and Address of Eachly Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval failure. List only one cause on each line Between Onset and Medical Death a. Hanging Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transit sician/Medical UNPENDED AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 5 certificate has been signed by the attrector, page 2 should be detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ģ Records, P. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autoosy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other: Scene 5 Residence 6 Other: Scene Inpatient ER/Outpatient 3 DOA this 1 🗸 Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Mar 22, 2010 (Month Day Year) Subject hanged self 1 Natural 1430 hrs Pending Director: d in by the f 1 Yes 2 ✔ No 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 100 Kearney Drive, Joppa, Md. determined (Specify) River the Funeral Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 23, 2010 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year NAR 26 2 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 02:15AM 50 m 03 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death **Examiner** to If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Birthplace /State or Foreign Funeral Year) Months Days Hours Min. 1 □ M 2 🗹 F 46 Director 2834 01/21/1964 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐¥es 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212/7 U.S.A items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. δ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) ract Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LWIS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) apt 58 red. Crnestina Jackson 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Marial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3-31-2010 21. Signature of Funeral Service License 22 Name and Address of Facility lass Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPTIC **Physician** SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Observed to compare the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions o Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O.1 1 Tyes 2 Tho been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HEMATOMA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DEBILITATION After this certificate has funeral director, page 2 s autopsy performed 1 ☐ Yes 2√2 No 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No N☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To eral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RESODO MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 5601, LOCH RAYEN BLYD, CAROLINE D'SOUZA BALTIMORE, MD 21239 MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ANITA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Jackson naela Larce 0024 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Maryland Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 M 2X F 02 Month Pay, 57 **Director** Year 53 212-60-9867 NJ Usual Residence of Decedent 28a-f shov 10b. County than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2102 Baker Street 21217  $U_{\bullet}S_{\bullet}A$ 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 9th grade na Bank Processor Harland Company Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Jackson Sr. Rosa Lampkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madgeline Burrell-Sister Baker Street, Baltimore, Md 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion 4/1/10 Baltimore, Md 21, Sibnaure of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ AIDS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events signed by the attending physician and deed be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 24 hours after death.

Funeral Director: After this certificate has been sign Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 X Yes 2 □ No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Deficiency Projection in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 1841459187 23 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine 22 Greene St. Baltimore yun

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 09292 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** SON PM 3:21 MARCH 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** AGNES HOSPITAL BALTIMORE NIA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 F Months Days Hours Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, if a Modical Exercise is a country on other traumatic event, if a Modical Exercise is a country on other traumatic event, if a Modical Exercise is a country on other traumatic event, if a Modical Exercise is a country of the provided and other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director NIA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Wabash 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seçondary (0-12) College (1-4or 5+) làth Machine **Perator** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Inez Speight ဂ္ Alonzo ADams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3912 Wabash Katherine Johnson-Maughter Balto. MD 21215 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Catonsville, mo 3-29-10 Cremata 4 ☐ Donation / > ☐ Other (Specify) 21. Signature of Fineral Service Licensee larch Funeral Home P.A. Fredhilfon Pass 23a. Part T. Epfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Theumonia days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** epsis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of): The law requires that the death certificate be executed Exam physician and s the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> ailure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2**>**100 Division of Vital 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after

To the Funeral Directory

completely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) amou 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Sout 00 BALTIMORE ANE AUREN ATON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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State of Maryland / Department of Health and Mental Hygions

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	/Medic	al	Fernande Lucette Jansa	T	March 23,	
: *	Examin	er	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center	4b. City, Town, or Location of Death  Cheverly		4c. County of Death Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo	y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	
	Director		153-28-6455 1□M 2뒀F 89 Yrs	Months Days Hours Min.	10-01-192	
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
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	r 28a-	irec	Maryland   Prince George's   Lar	ndover Hills 10f. Zip Code	10g.	Citizen of What Country?
	h with	al D	7403 Varnum Street	20784	Sv	vitzerland
	ems :	<b>Funeral Director</b>	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
5-0036	be filed within 72 hours after death with the Maryland and Hygiene.  ad other than "natural", or items 23a or 28a-f show event, I're Madical Exeminar must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 Year or Dates:	1 □Yes 227No Specify:	1110411, 0.03)	Specify: White
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baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke eny injury or other traumatic once.		21. Signature of Fundral Service Licensee	22. Name and Address of FacilityGary	y L. Kaufm sh. Blyd	nan Funeral Home at Elkridge, MD 21075
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shook, or heart failure. List only one cause on each line.			
F	Physician		l · · · · · · · · · · · · · · · · · · ·	ardiac Infar	ction	Onset and Death
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5	e law requires that the death cer has been signed by the attendir ie 2 should be detached for use	hysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)		Month Day Year
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	F 3 F 0		All man	D55559		ch 23, 2010
		}	30. Name and address of person who completed cause of death (Item 23a) (Typ		, all	25, 2010
			Thomas E. Maslen, MD, 7525 Greenway	Center Dr., Suite 31	2, Greenbe	elt, MD 20770
	Stat		31. Date filed (Month, Day, Year)  2. Registrar's Signature	ulis		
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Stoke		Margarita Korell MD					Penn Street,	Baltimore,	, MD 212	01			
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Kassakatis 20:36 РΜ March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Johns Hopkins Bayview Center 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 □XF Months Davs Hours Min. August 14,1932 216-30-9465 Director Maryland 77 Usual Residence of Decedent show 10b. County death with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Dundalk Marvland Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21222 USA 1818 Maxwell Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 ₩ Widowed 4 □ Divorced Specify: White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Sales Ladv Retail vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Shipley Henry Rodenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7021 Dunbar Road, Dundalk, Maryland Daughter Tena Baskette 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 29, 1 Burial 2 XCremation 3 Removal from State injury or Bayview Crematory 4 Donation 5 Other (Specify) 2010 Baltimore, Maryland Signature of Fundral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease Part 1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician, disease or condition resulting in death) Medical SCLEROTIC HEART DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and PULMONARY DISEASE attending physiciar OBSTRUCTIVE Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ò Pregnant at time of death Month Day Year ed by the ar P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes 2 1 N Division of Vital 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 R/Outpatient 3 DOA 27. Manner Leath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending work? 1 Tyes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Dundalu MD 21222 2 Markel

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph P. Kreis Month RCH Day 04:46 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Saint Joseph Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Hours 95-10-0822 89 Perrsylvania Director Usual Residence of Decedent show, 10c. City, Town or Location Parkville 10a, State 10b. County with the Maryland "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director MD Baltimore 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2802 Taylor Avenue 21234 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. Ď 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Mencal I 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bethelem Steel Elementary/Seconday (0-12) College (1-4 or 5+) Welding Engineer Be 17. Father's Name (First, Middle, Last)
Louise Kreis 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary A. Cochran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kreis / Wife 2802 Taylor Avenue, Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 3/27/10 Parkville, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility Evans Funeral Chapel & Cremetion Services 8800 Harford Rd. Farkville, MD 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician SEPTIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions. Examine if any leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant a 5 Other (specify) Month Pregnant at time of death detached 9 Unknown signed by d be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by POVOLEMIC 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe this certificate 1 Yes 2 No 1 ☐ Yes 2 XNo 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ¥ No 2 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) Natural Accident injury 5 Pending within 24 hours after death To the Funeral Director: A 1 Yes 2 No Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) the 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year) 3-22-10 D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO. DRIVE TOWSON, MARYLAND 32 Begistrar' Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gladys M. Kubski March 2010 2:30 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Pickersgill Retirement Community Towson Social Security Number If Under 1 Year | If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min 1 □ M 2 1 Months Days Hours (Month, Day 92 213-26-5360 Director Baltimore, Maryland 3/2/1 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Harford Baldwin Maryland 28a-f 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? United States ms 23a or must be r Funeral 2900 Squire Court 21013 of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc ö þ 1 Never Married 2 Married 72 hours after 21215-0036 white 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Elementary/Seconday (0-12) (Give kind of work done during most of working Baltimore City and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Public Schools 1st Grade Teacher Be traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Mullendore unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mr. Bruce V. Ensor/ nephew 2900 Squire Court Baldwin, Maryland 21013 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory of Evans Funera Chapel – Be 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, 21. Signature of Juneral Service License 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center 2325 York Road Timonium, Maryland 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Opset and Death Physician/ disease or condition Medical resulting in death) uence of Examiner Sequentially fist conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 5 Other (specify) cate has been signed by the page 2 should be detached a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed?
Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of of tifie 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

6701

J. Balts. Md 21200

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 15°, March 2010  $\mathbf{P}^{\mathsf{M}}$ Carol Fay Klinkner 1:32 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Shady_Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 9, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 😾 1936 Director 377-34-8911 73 Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show iral", or items 23a or 28a-f sl 1 ☐ Yes 2 😾 No Directo Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9504 Emory Grove Road 20877 **United States** Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ages 1 and 2 should be filed within 72 hours after ont of Health and Mental Hygiene.

If flem 27 is marked other than "natural", or itel or other traumatic event, If Medical Examinations. 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John V. Cotie Jacqueline E. Eberhardt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Klinkner/ Husband 9504 Emory Grove Road, Gaithersburg, MD, 20877 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any injury or o March, 19 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2010 Montgomery Crematorium 21. Signature of Euneral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc 210 MO1596 300 W. Montgomery Ave. Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Days Pneumonia /Medical Due to (or as a consequence of): Examiner Lung Cancer Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Day 5 Other (specify) After this certificate has deen signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş Pulmonary Fibrosis 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ∐Yes 2 kgNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation al or Attendi s after death. I Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital
within 24 hours a
To the Funeral I
completely filled

NBC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

16220 Frederick Road #213, Gaithersburg, Maryland Joseph A. Ball

State Registrar 29c. License number

D53317

29d. Date signed (Month, Day, Year)

March 16, 2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 029 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Collette Knight Kenneally March 20 Day 2010 Year 3:16 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 346-28-5388 1 □ M 2 🖾 F Months 74 July 935 Missouri Director Yrs Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director North Potomac Maryland | Montgomery 28a-f 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 14708 Native Dancer Road 20878 United States filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White "natural", Specify: Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve ပ pe. Harry Knight Clara McNeilly t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is marke njury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Kenneally/ Husband 14708 Native Dancer Road, North Potomac, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery
Crematorium, Inc. March Department of Important: If it any injury or conce. 1 Burial 2 🕱 Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 25 2010 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockvile, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 Signature of Funeral Service Licensee Rockville Rockville XO M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Soh sician/ DIDPULMONAR disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): OVARIAN attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atter in the past 12 months?

1 Yes 2 No the Hospital or Attending Physician: The law requires that the death hin 24 hours after death. Month Pregnant at time of death Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performe 2 No Yes 2 X No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one re and title of certific 29c. License number who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #5 Per FH G909 11/15/10 JH
State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 09300 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MILDRED MARCH KAUFMANN 2010 09:00A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ARDEN COURTS ASSISTED LIVING PIKESVILLE BALTIMORE Ti28ec20 Ng61 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Months Hours Min. 0672771929 Country) Director 80 Yrs NY Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7916 STEVENSON ROAD 21208 USA hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea gnoe, Elementary/Seconday (0-12) College (1-4 or 5+) 4 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAMUEL GINGOLD JULIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALAN KAUFMANN / HUSBAND 7916 STEVENSON ROAD, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PARK 03/25/2010 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License cotth 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events burial-transi resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death signed by the a g 🗌 Unknown g 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has page 2 perform Hospital or Attending Physician: The 1 Yes 2 No Yes 2 N Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital. Other: 1 Yes Z No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred → Natural (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, deeth provinced at the time, date and place, and due to the 29b. Signature and title of certifier ss of person who completed cause of death (Item (Type, Print) 10 103 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

		For State Registrar					rtificate of			s Are Legit giene Reg. No. 2	10	09301
Physicia	an	1. Decedent's Name (Fi	1 1				-		2. Date of Do	eath Day	Year	3. Time of Death
/Medic		Harrie							3	17 20		3:50 P M
Examin	er	4a. Facility Name (If not			ber)			or Location of De	ath	4c. County of Balto		
Francis		4106 Walte  5. Social Security Numb			7. Age (In vrs	. last birthday)	NO C	tingham		rth		place (State or Foreign
Funeral Director		212-34-9050		I□M 2∏F	7		Months Days	Hours Mi	n. (Month, D	18,1938	Cour	ntry)
		Usual Residence of Dec					<u></u>		march	10,17,70		
shov	J.	10a. State 10t	b. County		10c. C	ity, Town or Lo	cation				,	10d. Inside City Limits 1 □Yes 2X No
28a-f	Director	Md .	Balto	•		Nottin	gham 10f. Zip Code			10g. Citizen of W	hat Cour	
3a or	I Di	6 H Dunsir		ive				21236		Tog. Olizerror vi	US	
ms 2	Funeral	11. Marital Status		12. Was Deced	dent Ever in l	J.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin?	(Specify Yes or N	o- 14. Race		can Indian,
or ite		1 Never Married	2 X Married	Armed Ford 1 ☐ Yes If Yes, Give	2X No		if Yes, specify Cut 1 □ Yes 2¶ No		erto Hican, etc.)		k, White,	etc. i <b>it</b> e
ural",	d by	3 Widowed 4 🗆		Year or Da	tes:					Specify.		
"nat	lete	15. (Specify o	Decedent's E	ducation a <i>de completed)</i>		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	upation e during most of w	orking	16b. Kind of Bu	siness/In	dustry
jiene. r thar	Completed	Elementary/Secondar	ry (0-12)	College (1-	4or 5+)		maker	04)		Н	lome	
othe othe /ent,	Be C	17. Father's Name (Firs	st, Middle, Last	)				18. Mother's N	ame (First, Middle	e, Maiden Surnam	e)	
Menta arked atic e	ToE	Harry E. Ro	ouzer					Jane I	. Reidy			
ismo		19a. Informant's Name/	/Relationship (	(Type. Print)		19b. Maili	ng Address (Stree	et and Number or	Rural Route Num	ber, City or Town,	State, Zip	o Code)
lealth im 27 iher tu		Albert L. J		r. Sp	ouse		Dunsinar			ham, Md.		
or of		20a. Method of Disposit 1 SyBurial 2 □ Cr	remation 3		tate 20b.	cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location -	City or 10	own, State
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rediffed at once.		4 Donation 5 ☐ 21. Signature of Funera			Ar		Nationa  Name and Addr		25-2010			
any any once		Dietau	W K	Din Po				2		k Funeral		
		23a. Part 1. Enter the d	isease, or com	plications that ca	used the dea	ath. Do not en				gham, Md. arrest,		Approximate Interval Between
ysician		shock, or heart fai Immediate Cause (Fina disease or condition				c. Lun	a Cancer	^				Onset and Death
Medical		resulting in death)			or as a conse		)				-	
caminer	7	Sequentially list condition	ons,	b								
n and ial-transit	Examiner	Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injure)	diate ng ry	Due to (c	or as a conse	quence of):						
cian and urial-transit	Exar	that initiated events resulting in death) Last		cDue to (c	or as a conse	quence of):						
attending physician for use as the burial	_		•	_d								
ing pt e as th	Physician/Medica	IF FEMALE:										
or use	ian/	23b. Was decedent pre in the past 12 mor			irth 2 Fe	tal death 3	Ectopic pregnar	псу		23d. Dat Mo		very Day Year
the s	ysic	1 □Yes → No 9 □ Unknown	0	4 ☐ Pregn 9 ☐ Unkno	ant at time of wn	death 51	Other (specify)					
been signed by the should be detached		Part II. Other significan	nt conditions	contributing to de	ath but not re	esulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco use contr	ribute to t	the cause of death?
n sigr Ild be	d by								_ 1□	Yes 2 No	3 ☐ Pro	bably 4 Onknown
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	om								per	formed?/	leath?	ompletion of cause of 2 □ No
certificate h rector, page	Be C	25. Was case referred t	to medical					26. Place of D	leath (Check only	one)		
this co	To	1 Yes 2 No		J	·	☐ ER/Outpatie	III OLI DOA	ther: 4 \(\sime\) Nursing	Home 5 1	sidence 6 XOth	augn er <i>(Sp</i> eci	ter's Residence
After funera	ion:		Pending		of Injury h, Day, Year)	28b. Time of Injury	Wo		28d. Describe	how injury occurr	ed	
within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	ficat	2 ☐ Accident 3 ☐ Suicide 6	investigatio	e co- Bi	of Injury - At	home farm st	M 1 [	□Yes 2□No	28f Location	(Street and Numb	er or Rus	al Route Number
Dire d in b	Certification:	4 ☐ Homicide	determined	buildin	g, etc. (Spec	cify)	oot, radioly, olivat			own, State)	ci oi rian	ar riodic ridinger,
hours Inera ly fille		29a. Certifier 1	Certifying P	hysician: To the	best of my kr	nowledge, dea	h occurred at the	time, date and pla	ace, and due to th	e cause(s) and ma	anner as	stated.
the Fu	Medical	one)		and mann	er stated.	nation and/or ii	nvestigation, in my	opinion, death of	curred at the time	e, date and place,	and due t	to the cause(s)
<b>6</b> 00	2	29b. Signature and title	- 1/					nse number	_	29d. Date signed	(Month,	
			Rajupak					005746				
V		30. Name and address N.S. Raja	of person who	completed cause	e of death (Ite	em 23a) (Type, いかけり	Print) AV.) Suite	235	Baltimore	e, MD. 2	120	9.
Sta	te	31. Date filed (Month, D	Dav. Year)	32. Re	aistrar's Sign	nature		/				
Registr	ar	MA	AR 262	2010	un	1. 1	barker					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Herman Kenneth Loudenslager 2010 MAZO - 01 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a BALTIMORE ST. AGMES HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9/22/1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 X M 2 □ F 219-30-6252 74 **Director** Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or items 23a or 28a-f show Director 1 □Yes 2 X No MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1500 Woodcliff Avenue 21228 Usa Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens important: if Item 27 is marked other the any injury or other traumatic event, 1 m. 900.8. Supervisor Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna L. Crosby George A. Loudenslager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Cater / Niece P.O. Box 394, Manchester, Maryland 21102 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 3/26/2010 | Brooklyn Park, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral HOme, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIDMYSPATHY 10 years /Medical Due to (or as a consequence of): Examiner 5 HOCK LIVER Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed AFIB 10 years and -tran Due to (or as a consequence of): burialattending physician for use as the buria 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l certificate Division of Vital 1 ☐ Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending within 24 hours after usa...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 22,2000

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) caton

MUL

900

31. Date filed (Month, Day, MAR)

24062

MD

21229

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Loudermilk Franklin March :15 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7929 North Point Road Edgemere Baltimore . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Date of U. (Month, Day, 1 **Funeral** 1 M 2 - F Days Months Hours ,1962 Director 218-88-5549 47 June Virginia Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Baltimore 1 Yes 2X No Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7929 North Point Road 21219 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or ite Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry within Hygiene.

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'the Me (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 years Dispatcher Trucking Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic eve ဂ္ James Norman Phyllis Loudermilk t. Page 1 and 2 should be treet of Health and Men trant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7929 North Point Road, Edgemere, Maryland Barbara Fox Companion Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. March 25, 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. r complications that caused the dea Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ bolastale aderstarieren disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year 4 Pregnant 9 Unknown signed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes peen 24a. Was an . Were autopsy findings available prior to completion of cause of rector, page 2 s autopsy death?
1 Yes 2 No perforn 2**4** No Yes Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes 2 No ည Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide in by 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital 24 hours Medical 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 **Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ucar

State Registrar 4940 ENTEN AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUFTELL

32.

21 31. Date filed (Month, Day, Year) - JH8VML

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#31perDVR, G901, 3/26/2010, WS

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year prover 24,2010 /Medical MIC 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ñ 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Social Security Number 6. Sex last birthday **Funeral** Months Days Year Hours Min. 1 M 2 F BROHIMA Director Usual Residence of Decedent 10a. State 10c. City, 10b. County Town or Location 10d. Inside City Limits or 28a-f show or other traumatic event, the Medical Examiner must be notified at TIMONE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 'natural", or items 23a within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Pres 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. It a Market Elementary/Secondary (0-12) College (1-4or 5+) TOCHANIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) -NIBUE DR Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a 1 Burial 2 ☐ Cremation 3 Removal from State 5 ☐Other (Specify) 4 Donation 21. Signature of Funeral Service License 22. Name and Address of Facility VARC Approximate Interval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc o eart failu Immediate ause (Final disease or condition resulting in death) eart failure. List only one cause on each line. **Physician** costate /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Univerlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 I Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Š 2 XNO 3 Probably 4 Unknown 1 Tes Completed 24a. Was an autopsy performed 1 ☐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 □ No within 24 hours after death. To the Funeral Director: A completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Simatu 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type) Print) 31. Date file State 6 R 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day Month MARCH VALDORE ARCULEER LANGFORD 10:46FM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Saint Joseph Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**½** F Days Hours (Month, Day, Year, Country) Louisi Director 435-22-0306 87 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Harford 1 Yes 2 No Maryland Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1309 A Scottsdale Drive 21015 USA Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 9 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afti. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the M-di-al Exar once. If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) conday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas John Arculeer Alberta Beatrice Saint Julien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Marie Foster / Daughter Box 150, Accident, Maryland 21520 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) <u> Hilltop Service Corp!3-24-10</u> Towson, Maryland . Signature of Funeral Service License 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ AORTIC STENOSIS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 124 hours after death.
Funeral Director. After this certificate lated filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X**No Other: ျု 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 22-10 030263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed #

26

DRIVE

TOWSON, MARYLAND

7601

32. Registrar's Signature

			State	ate of Mary		artment of F		nd Mental Hy	201	0 09306
			Registrar  1. Decedent's Name (First, Middle, Last)		- Cei	uncate of L	Jealii	2. Date of De	Reg. No. LU	
	Physicia Medic		Louise	Irene	Lindho	o1m			22 Day 201	3. Time of Death 1:10 P M
	Y Examir		4a. Facility Name (if not institution, give street a			4b. City, Town, or	Location of		4c. County of I	Death
-			5708 Bradley Bouleva	ard		Bethe	sda		Montgon	
	Funeral		5. Social Security Number 6. Sex	XIF	yrs. last birthday)	If Under 1 Year Months Days	If Under 2 Hours		th g.	Birthplace (State or Foreign
	Director		306-20-2021	86	Yrs.			Septembe	r 24,1923 Wa	Country) shington, D.C.
	and Show at	5	10a. State 10b. County	100	c. City, Town or Loc	cation				10d. Inside City Limits
	Aaryla Ba-f tified	rect	Maryland Montgomery		Ве	thesda				1 ☐ Yes 2 💢 No
	the l	ā	10e. Street and Number		-	10f. Zip Code			10g. Citizen of Wha	t Country?
	s 23, nust I	Funeral Director	5708 Bradley Boulevan	rd		2	0814		United St	ates
	death item ner n		11. Mantal Status 12. Wa	s Decedent Ever i ned Forces?	n U.S. 13. V	Vas Decedent of Hi	spanic Origi n. Mexican.	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - /	American Indian,
36	after al", or xami	d by	O TV NACIONAL A D Division I If Y	ned Forces? Yes 2 X No es, Give		☐ Yes 2 🛣 No			O	Vhite, etc.
õ	atura cal E	Completed	15. Decedent's Education	er or Dates.	16a Deced	ent's Usual Occupa	ation		, , , , , , , , , , , , , , , , , , ,	Mhite
75	n 72 h an "n Medi	Ē	(Specify only highest grade complete (Specify only highest grade complete)  Elementary/Seconday (0-12)  Col	oleted) lege (1-4 or 5+)	(Give k	rind of work done d O NOT use retired)		of working	16b. Kind of Busin	ess industry
21	withii giene er th		Elementary/Secondary (5-12)	4	Scient	ific Res	earche	er	Gnotobio1	logist
pu	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Middle,	Maiden Surname)	
yla	Meninarke		Laurence H. Reynolds				Sybi	1 O. L. Ow	en	
Maryland 21215-0036	should be filed with h and Mental Hygier 7 is marked other t traumatic event, th	П	19a. Informant's Name/Relationship (Type, Prin	*		-		or Rural Route Numbe		
e,	and 2 Health em 2 ther 1		Linda White / Daught 20a. Method of Disposition				Soulev !			1and 20814
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🖾 Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State		atory or other place	· .	Date	20c. Location - Cit	
ŧ	artme bartme bortar injur		21. Signature of Funeral Service Licensee	MC				rch 24,2010		
Ä	permit Depar Impoi any in		John Johnson	мо:	1360   Roi	pert A. Pum 7 Wisconsi	ohrey F n Avenu	uneral Home/H ie, Bethesda,	Bethesda—Chev Maryland 20	vy Chase, Inc. 1814 <b>–</b> 3501
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the	death. Do not ente	r the mode of dying	g, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between
	Physician/	Ш	Immediate Cause (Final disease or condition		rebrovaso	ular Acc	ident			Onset and Death
	Medical Examiner	Ш	resulting in death)	ue to (or as a con	sequence of):					
		e e	Sequentially list conditions, if any, leading to immediate	ue to (or as a con						
1.	ted nsit	dical Examiner	cause. Enter Underlying Cause (Disease or injury	rue to (or as a con	isequerice oi);					
My	execu in and ial-tra	l m	that initiated events c c	ue to (or as a con	sequence of):		_			
09	ate be executed physician and the bunal-transit	lical	d							
		Mec	IF FEMALE:							
9 ×	th cer tendi or use	ian/	23b. Was decedent pregnant 23c. If you	es, outcome of pro	Fetal death 3 _	Ectopic pregnancy	y		23d. Date of	,
Bo	s dear the at hed fo	ysic	1 ☐ Yes 2 🗓 No 4 💆	Pregnant at time Unknown	e of death 5	Other (specify)	·		Month	Day Year
P.O. Box 687	es that the death certifica igned by the attending pl be detached for use as t	Completed by Physician/Me	Part II. Other significant conditions contributing	ng to death but no	t resulting in the ur	nderlying cause give	en in Part I.	23e Did to	obacco use contribut	te to the cause of death?
S, F	ires that signed I d be det	g								Probably 4 Unknown
ord	requ been shoul	ete						24a, Was		e autopsy findings available
ec	ne lav e has age 2	E						autor perfo	psv prior	to completion of cause of h?
al F	an: Ti tificat tor, pa	BeC	25. Was case referred to medical			26. Pla	ice of Death	(Check only one)	2X No 1	Yes 2 No
<b>K</b> it	ysici lis cer direc	일	examiner?  1 Yes 2 No Hospital	1 Inpatient	2 ER/Outpatien	Cul-	r·	sing Home 5 K Resid	dence 6 Other (S	(necify)
of	ng Pł fter tł ineral		27. Manner of Death 1 X Natural 5 □ Pending	Date of injury (Month, Day, Yea	28b. Time of injury	28c. Injury work	at		now injury occurred	
Ö	tendi leath lor: A the fu	itic;	2 Accident Investigation			M 1□	Yes 2 N	ło		
Division of Vital Records,	or At after of Direct in by	Certificate:	4 Homicide determined 28e.	Place of Injury - A building, etc. (Sp	At home, farm, stre ecify)	et, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certifics within 24 harous after death.  To the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Medical (	29a. Certifier 1 X Certifying Physician: To	the best of my ki	nowledge, death o	ccured at the time	date and nic	ace and due to the co	use(s) and monner or	s stated
	ne Ho n 24 h le Fur	Medi	(Check 2 Medical Examiner: On to only one) 3 Certifying Nurse Practi	the basis of examin	nation and/or investi	gation, in my opinion	n, death occi	urred at the time date a	and place, and due to t	the cause(s) and manner stated
	To the vithin comp		29b. Signature and title of certifier		NO	29c. License			29d. Date signed (M	onth, Day, Year)
			Miparalgo	mer		D276	60		3/23/1	0
	15		30. Name and address of person who complete				10 -	1 . 4 . 4	W 1 1 1	20052
			Alpana Goswani, M.D.  31. Date filed (Month, Day, Year)			Pike # 1	10, R	ockville,	Maryland 2	20832 
	Stat Registra	C	MAR 2.6 2010 2-1	32. Registrar's Si	ignature	•				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Hisdasi) -6:20 AM 03 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HESAPEAKE Med. BEL Die HARTORD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days Hours Min (Month, Day, Year, Director 212-40-637 03-4-194 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning House Keeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ HEARTLONE Helma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rope mo 21154 STREET DeboRAH 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 3-27-2010 4 Donation 5 Other (Specify) BAUTIMORE, MD 21. Signature of Funeral Servide Lice 2134 Willow Speiking 51333 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician disease or condition 0 Medical resulting in death) **Examiner** year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Fetal death Pregnant at time of death 5 Other (specify) Month Day Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy nerform death? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

MAR 2

1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician DEBORAH 9=154M 224 2010 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Bon Secour Hospital Baltimore
[Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🛣 F 58 Director 216-56-8594 02/02/1952 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f sho event, the "scieal Examinar must be redified at 1 XYes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 5130 Belair Road Funeral 21206 S A

14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2M No Specify. ģ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1year Physical Therapist erapist Hospital 18. Mother's Name (*First, Middle, Maiden Sürname*) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Loretta T. Holly Theodore Carter and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is. any Injury or other trau. Nakia Scott 5130 Belair ROad, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place)

Joseph Brown F/H and Date 20c. Location - City or Town, State 20a. Method of Disposition 3/26/2010 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) unk unk Crematory Baltimore, MD Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 21. Signature of Funeral Service Licensee which N. W illiamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYNCARDIAL INFARCTION disease or condition resulting in death) /Medical Examiner ARTERIOSCLEROT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed EKRONIC the burial-tran Due to (or as a consequence of): the attending physician ned for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Year 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by HYPERTENTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HEPAT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate HHMAN DEFICIENCY YIRUS 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of De th 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 29a. Certifier 1 To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

Registrar

31. Date filed (Month, Day, Year)

SUDKIR

29b. Signature and title of certifie

32. Registrar's Signature

PATEL.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.

DHMH 17 Rev 1/2001

13.0.

29c. License number

2000 W. BALTO, ST,

D 23300

BON JELUNRS

29d. Date signed (Month, Day, Year)

101313

MARCH 24 2010

BA2TU 175, 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mcculloh **Physician** March 22,2010 Miriam 2:15P /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ivy Hall Middle River Balto. If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 F 94 Yrs. Director 216-10-3095 December 5.1915 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director Md. Balto. Nottingham 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 4026 E. Joppa Road USA 14. Race - American Indian, 21236 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☑ If Yes, Give Year or Dates: 2XNo 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Wiseman ဂ္ Mary Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR Patricia Hershberger 4026 E. Joppa Road Nottingham, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-25.2010 | Fullerton, Md. St. Joseph Cemetery 21. Signature 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardia Physician /Medical Due to (or as a consequence of): Examiner SCIP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed Due to (or as a consequence of): P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ cate has been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Ž No Other: ို 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

31. Date filed (Month

29b. Signature and title of certifier

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

21202

Amend #2, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 0 0 1. Decedent's Name (First, Middle, Last) Date of Death 3/23/2010 Physician Month nah 101115 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, of Location of Death County of Death Examiner Baltimore Baltimore Levindale 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days Year) Months Min. Hours 1□M 2₩F 06 **Director** 85 10 214**-**38-1838 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ortant: If Item 27 Is marked other than "naturel", or Items 23a or 28a-f shov Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> **Funeral Director** Baltimore X Yes 2 No MD NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 U.S.A. 730 Roundview Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny Injury or other traumatic more Elementary/Secondary (0-12) College (1-4or 5+) Home llth grade na Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melton Brooks Julia Galloway 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 Roundview Road, Baltimore, Md 21225 <u>Irvin Harrison Morris</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet 3/30/10 4 Donation 5 Other (Specify) Owings Mills, Md 21. Signature of Funeral Service Licensee March F/H West Baltimore, 4300 Wabash Ave, 21215 Far1. It ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 minut /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be execu Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4⊡Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Tilnknown Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 32 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform bdomina 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide NuAse Prochtoner within 24 hours a To the Funerel L CertifyIng Phys en: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) CRNP ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 6095 MARShalee Dr. EIKAdge Md 21075 ARIE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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	Dhysici	20	1. Decedent's Name (First, Middle, Las	it)				2. Date of Death Month	n Day Year	3. Time of Death
	Physici /Medic		Catharina V.					March 24	2010	9:22 A. M
	Examin	er	4a. Facility Name (If not institution, give				or Location of Deatl	h	4c. County of De	ath
			Harford Memorial  5. Social Security Number 6. S		e (In yrs. last birthda		de Grace r If Under 24 Hrs.	8. Date of Birth	Harford	rthplace (State or Foreign
	Funeral Director			DMAGE	76 Yrs.	Months Days		July 29	Year)	olland
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	leath	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 1				Inited Sta	
0	riter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ ✓	No		Hispanic Origin? (S ban, Mexican, Puert	o Rican, etc.)	Black, Wh	ite, etc.
ž	ral', o	by	3 ☐ Widowed 4 🙀 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify: Wh	ite
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		o Be	Clemens Moeller					th Driess		
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aitimor	Page nent cont: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Evans F	ineral CH	apel!:~~~	ch 25, 2010 F	orest Hil	l, Maryland
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מ	8258		Jan XC	raugh		Newport	Drive Fo	rest Hill	, Marylan	d 21050
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each li	the death. Do not					Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence (f):	11:2 /	THA 05.	2		
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	0 0 0	Sici	in the past 12 months?	4☐Pregnant at 9☐ Unknown		Other (specify)			Month	Day Year
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	To the Hospitel or Attending Physician: The inwithin 24 hours atter death. To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example 1	ysician: To the best niner: On the basis of and manner sta	examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	e, and due to the ca arred at the time, da	use(s) and manner ate and place, and di	as stated. ue to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	16	1.	29c. Licer	nse number	29	d. Date signed (Mo	nth, Day, Year)
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			30. Name and address of person who		leath (Item 23a) (Typ	e, Print)	1 1	111	1.19.	7/1
			31 Date filed (Month Day Year)	001 P O	35/	14119	WIL	1446	1 /Val x 10	43
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 06-22 AM MORELAND MARCH GLADYS 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/19/1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Min. 1 □ M 2 🔀 F Months Days Hours Wales 414-78-1140 85 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Columbia MD Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 USA 5610 Vantage Point Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 □ Yes 2 No White Baltimore, Maryland 21215-0036 Specify: Specify: à Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, its Medie once. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown John Kampbell ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5610~Vantage~Point~Rd.~Columbia,~MD~2104419a. Informant's Name/Relationship (Type. Print) Susan Gooder/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State W. Arundel Crematory Odenton, MD 3/25/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory P.A. 21. Signature of Funeral Service Ligensee 1411 Annapolis Road Odenton, MD 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BILATERA PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) cate has been signed by the page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 212 No 1 ☐ Yes 2 ☐ No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica After this certification, tuneral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2□Mo Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00053150 senticgo Rd suite 11 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9630 leunmale uple 21045 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 26 2010 Registrar

		For State of State of Registrar	Maryland / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>		, ,	iene eg. No. 2 N 1 ()	0031	
Physici /Medic	_	1. Decedent's Name (First, Middle, Last)  Martha M.	Manke			2. Date of Deat Month March 2		3. Trime-of Death 7:00 a. M	
Examin	- 4	4a. Facility Name (If not institution, give street and numb Sacred Heart Nursing Hom		4b. City, Town, or Hyattsvi	Location of Death		4c. County of Death Prince Geo		
Funeral Director		5. Social Security Number 6. Sex 1	Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, May 12,	Year) 14 Coni	nplace <i>(State or Foreign</i> <i>Intry)</i> necticut	
within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County  MD Prince Georges	10c. City, Town or Lo					10d. Inside City Limit	
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ent of Health		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from St 4 Donation 5 Other (Specify)	20b. Place of Dispo	osition (Name of	150	Rate ₂₅ ,	20c. Location - City or Beltsville	Town, State	
Departm Importar any injui		21. Signature of Funeral Service Licensee					l & Cremat g, Marylan		
Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events	rdial Infarc r as a consequence of): hmia r as a consequence of):		ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death minutes years	
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ine iaw ate has b page 2 s	Completed					24a. Was a autop perfor	sy prior to death? 2 1 No 1 □ Yes	utopsy findings availa completion of cause 2 No	
this aldi	cation: To Be	25. Was case referred to medical examiner?  1	OF -	28d. Describe h	lence 6 □Other <i>(Spe</i> low injury occurred				
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n 24 hours and Funeral pletely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the ba and manner: On the ba and manner.	sis of examination and/or i						
To the within 2 To the Complex	Me	29b. Signature and title of certifier	21.	29c. Licens	6609.		3. 2 4.		
		30. Name and address of person who completed cause Raman Tuli, M.D. P.C., 1	of death (Item 23a) (Type 10810 Darnes	e, Print) town Rd.,	Suite 20	2, Gaitl	hersburg, M	ID 20878	
St	ate		gistrar's Signature	9					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Day 2010 Physician/ March Che Shut Mon 23 LO:50 A Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Montgomery Washington Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** China China Days Hours 1 □ M 2xx 03-08-1934 064-72-2355 Director 76 Usual Residence of Decedent 10a. State 10b, County 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Clarksville MD Howard 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21029 United States 6941 Crossfield Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify Specify: Completed 3 Widowed 4 Divorced Asian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Salesperson Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jin Tang Shu Leung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6941 Crossfield Court, Clarksville, MD 21029 Irene Mon - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Dopation 5 Other (Specify) Atlantic Crematory 03-25-2010 Glen Burnie, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Fundal Sertice AR. MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause in each line. Approximate Interval Between Onset and Death 23a. Part Immediate Cause (Final Pnysiciana Woma Medical resulting in death) Due to (or as a consequen of o Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 L 1 🗌 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No 은 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Praction To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mo

Day, Year)

MAR 26 2010

480

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Day 25 Physician / Medical 2:10 A M bernara March 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** N/A8. Date of Birth (Month, Day, Yea May 1, 19 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Days Hours 1 XM 2 F 78 1931 Virginia 223-38-4241 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1X Yes 2 No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? death with 421 North Milton Avenue 21224 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 2 Yes 2 No 196
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 2□No 1960-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 Widowed 4 Divorced 1962 Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) I be filed withir ntal Hygiene. Is marked other than Stee1 Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic evone. Kemp Morris Clara Morris ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) E. Louise Morris/ Wife 421 North Milton Avenue, Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 25. 1 🗆 Burial 2 X Cremation 3 🗆 Removal from State Metro Crematory, Inc. 2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician SC PSIS

Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examiner Due to (or as a consequence of) the attending physician and ched for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 □ No page 2 should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 🗌 Yes 3 Probably 4 🗍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv has performed 2 1 No 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Physiclan: Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 🗆 DOA 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.O. Records, of Vital

l or Attending Fafter death. Division Director; To the Hospital within 24 hours a To the Funeral C

State Registrar DHMH 17 Rev 1/2001

KAVITA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifi

29a. Certifier (check only

one)

Medical

SHARMA

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 26

32. Registrar's Signature

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

March 25,2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a benefith, G902, 4/21/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03 20 2010 1850 M Haywood Odoms Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Ritchie Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** N. Carolina Days Hours 1 X M 2 □ F 12/10/ 212-58-2048 1951 Director 58 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21223 U.S.A. 1900 W. Baltimore Street Apt 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2X Married Completed by Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: "natural", Black or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Poultry 5th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alexander Odoms <u>Ulersee McDuffie</u> permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumationce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 W. Baltimore St. Apt A, Balto., MD 21223 Keisha Green(Niece) 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20b. Place of DISPOSITION INVALIDES:

cametery, crematory of other place)

Seph Brown FH & Crematory

Mt. Carmel Com. Burial 2 X Cremation 3 ☐ Removal from State 4/15/2010 Unk-4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee ²²Josephdom of Fallyown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cirrhosis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner actitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury o (or as a consequence of): **Hospital or Attending Physician**: The law requires that the death certificate be executed 24 hours after death. detached for use as the burial-transi attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 09/89 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 No Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Records, After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) hospice hous 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: @ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation **Director:** 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) K107936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Eutaw Street Baltimore, MD 2/20 Camille Menino 31. Date filed (Month, Day, Year) State Registrar

Odoms

Haywood

30/10

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month MAR **Physician** 2010 Harold Patterson Sr. /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TIMORE lasoita anes If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number Sex 7. Age (In yrs. last birthday Funeral 1 □ MM 2 □ F Yrs 08/10/ 1942 Maryland 216-42-1426 67 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State sa or 28a-f show the notified at show 1X Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 7 is marked other than "natural", or items 23a traumatic event, the Modical Examination 21225 Funeral 219 Bishop Avenue U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates; 1 Never Married 2 XMarried Specify: Black 1 □ Yes 2 □XNo Specify. ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NOVATEC Sheet Metal Mechanic 12th Grade Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) MITERSON Be ( 17. Father's Name (First, Middle, Last) 2 should be fi J. Smith Audrey Patterson ၀ Calvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Bishop Ave., Baltimore, MD 21217 Althea Patterson(wife) Department of Heal Important: If item 2 any Injury or other 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/31/10 | Baltimore, MD King Mem. Park 21. Signature of Funeral Service Licensee Joseph Address of Ecology Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause un each line. Immediate Cause (Final disease or condition resulting in death) **Physician** myelogenous 1015 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitiated events resulting in death) Last Examiner be executed ician and burial-tran Due to (or as a consequence of): physician sthe burial Box 68760, Physician/Medical law requires that the death certificate attending p SS IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this After this funeral of 27. Manner of Death 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Matural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifie mD muly 30 Name an son who completed cause of death (Item 23a) (Type, Print) Baltimare MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

au

31. Date filed (Month, Day, Year)

MAR 26 2010

32. Registrar's Sign

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day WALTER OUINTEN **POHLHAUS** 5:40 PM MARCH 22 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1720 WILSON POINT ROAD BALTIMORE MIDDLE RIVER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1-18-1925 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours 1 € M 2 □ F 216-20-3513 85 MARYLAND Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE MIDDLE RIVER Director 1 ☐ Yes 🏋 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1720 WILSON POINT ROAD 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Xves 2 No If Yes, Give Year or Dates: 1943-46 1 Never Married 2X Married 1 ☐ Yes 2 ☐ No Specify: þ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER SALES 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) **POHLHAUS** AGNES (SCHUTTE) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 913 LONG POINT ROAD MARK G. POHLHAUS/SON GRASONVILLE, MD 21638 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Removal from State 2 ☐ Cremation 3 ☐ Removal from State HOLY REDEEMER CEM 3-26-2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GRON Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ☑ No 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

death certificate be executed and burial-trar P.O. Box 68760. for Records. Hospital or Attending Physician: The Division of Vital funeral after death. Director: Af

**Funeral** 

Director

r than "natural", or items 23a or 28a-f sh the Medical Examinar must be notified

with the Maryland

death

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7½. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Modic once.

**Physician** '--/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

469

State Registrar

e Funeral I

within 2

Medical

31. Date filed (Month, Day, Year)

FAUS

30. Name and address of person with

22. Registrar's Signatur

completed cause of death (Item 23a) (Type

1111

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 000 Physician/ Medical Facility Name (if not institution, give street and or Location of Death **Examiner** 4c. County of Death right of Manyland Medical Center Ba TIMOVE If Unde If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 10 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Min 218-64-4155 Director Usual Residence of Decedent 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗌 Yes 2 🔀 No Abingdon Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1400 Emily Court East 21009 USA ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Year or Dates White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygelen. Important. If item 27 is marked other than "natu any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Steel Worker</u> Steel Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kenneth Woodrow Parson Marie Matilda Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Lou Parson / Wife 1400 Emily Court East, Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Hilltop Service Corp. 3-25-10 Towson, Maryland . Signature of Figueral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Pay Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Month Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 Other: nours after death.

neral Director: After this confilled in by the funeral dire 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury Manner of Death 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number

State Registrar S. breene

Baltimore, MD

of death (Item 23a) (Type, Print)

of person who completed cause

Ellani 2

32. Registrar'

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh e901 3-29-10 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 25, 2010 JOHN WALTER POLEK 11:22A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella MAris Timonium Baltimore Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours XX M 2 D F 219-01-0802 93 Sebtember 11, 1916 MarvPand Director Yrs Usual Residence of Deceden shov 10b. County 10a. State 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director or 28a-f Maryland 1XX Yes 2 No None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 100 East Lake Avenue 21212 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

*XX Yes 2 \sum No WWII Black, White, etc. ò 1 Never Married 2 Married hours after 1 ☐ Yes 2XX No Specify. If Yes, Give Year or Dates Baltimore, Maryland 21215-003 XX Widowed 4 Divorced Specify: White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 0wner Marina Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Frank Polek Ida Julia Waryjasz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 East Lake Avenue Baltimore, Maryland 21212 Janet Polek <del>Reis</del>- Ries Dtr Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Dulaney Valley Mausoleum March 27,2010 | Timonium, Maryland ☐ Donation 5 ☐ Other (Specify) ignature of, Funeral rviće Lio sec 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 rications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest the cause on each line. 3a. Part 1. Enter the disease, or co shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician . Stage disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, Completed 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy performed 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Division 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 24 XXCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie

State

JOHN

2010

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pagh trar's Signature

CRNP

JENNIFER HAUF,

31. Date filed (Month, Day, Year)

K15

2300 DULANEY VALLEY ROAD

29d. Date signed (Month, Day, Year)

TIMONIUM

25/2010

21093

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 24 ^D2010 Edwin F. Roesler 3:56 P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air HArford 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Year) 1943 Maryland Days Min. 1 X M 2 - F Months Hours (Month, Day, Yean, 24) **Director** 215-42-8869 67 Jan. Usual Residence of Decedent 28a-f shov 10a. State 10b. County aţ 10c. City, Town or Location Director 10d. Inside City Limits notified 1 Yes 2XXNo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? Funeral items 23a 201 J. Yorkshire Way 21014 United States 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner ò Never Married 2 Married Completed by 1 ☐ Yes 2 XXNo If Yes, Give 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Fenceman Home Improvement 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of <u>0</u> permit. Page 1 and 2 should be f Department of Health and Menta mportant: If item 27 is marked Edwin F. Roesler Dorothy Blamberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Hoopes / Sister 4772 Norrisville, Road White Hall, Maryland 21161 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State any injury or Evans Funeral of Chapel March 29, 4 Donation 5 Other (Specify) Air 2010 Forest Hill, Maryland 21. Signatural f Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Bel Air
B Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or composition of the shock, or heart failure, List only on ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to or as a consequence of **Examiner** Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 🗆 No 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pardiomyopathy 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas e 2 s autopsy page performed? Yes 2 No certificate 1 Yes 2 No Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this ( 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death Date of injury Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work' Division 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) completed filled in 24 hours Medical 29a. Certifie 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my kn. who give death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Monty Day, Year)

6

32. Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCI Joseph Nelson Rinehart, Jr. 4:55P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Joseph Medical Center Baltimore 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g, Birthplace (State or Foreign **Funeral** Months Days Hours Min. Dec. 08, 1919 218-03-5797 Director 90 Baltimore, MD. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Timonium Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 2300 Dulaney Valley Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give than "natural", Specify: White 3 Widowed 4 Divorced W.W.II Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) 72 Painting and Elementary/Seconday (0-12) College (1-4 or 5+) N/A should be filed within and Mental Hygiene. Self Employed Painter/Decorator Decorating 12 item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna M. Fitzpatrick Joseph Nelson Rinehart, Sr. 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2300 Dulaney Valley Road C003 Timonium, MD.21093 1 and 2 s of Health a item 27 i Mary Agnes(nee Knauff)Rinehart 20a. Method of Disposition 20b. Place of Disposition (Name of March 25, 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill, Maryland 21. Signature of Funeral Service Licensee, Jeffrey L. Gair, Sr. 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. Timonium, Maryland 2325 York Road 23a. Ran 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ RESPIRATORY FAILURE SECONDARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TO LUNG CANCER Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): death certificate be executed CORONARY ARTERY DISEASE sician and burial-trans UNKNOWN that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the nding pr. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? jo Pregnant at time of death Month Day Year Yes 2 No 9 Unknown 9 Unknown P.O. | ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed k I be deta 23e. Did tobacco use contribute to the cause of death? Completed by CONGESTIVE HEART FAILURE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No MYOCARDIAL INFARCTION 24a. Was an page 2 autopsy Physician: The ATRIAL FIBRILLATION 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending s after death.

I Director: After the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiners: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 29b. Signature and title of certif 29c. License number 29d. Date signed (Month. Day, Year) D58944 March 25, 2010

State Registrar

DHMH 17 Rev 7/2009

7601 OSLER DRIVE

TOWSON. MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 26 2010

BOUTZALE.

32. Register's Signature

CHRISTINE L

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09324 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 22, 2:30 P M Joseph Vincent Rohr Sr. March 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 ☑ M 2 ☐ F **Director** 213-14-4219 88 24. 1921 Marvland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and by Intifficial 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 Bedford Road 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∀es 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∏Yes 2 No þ Specify Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Inspector County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Bernard (unk) Rohr Mary Catherine King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph V. Rohr Jr. / Son 826 Turtle Creek Ct., Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 3-27-10 Timonium, Maryland A Funeral Service Licensee McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 50 W. Broadway, Bel Air, MD 21014 Immediate Cause (Final **Physician** Meumonis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Seps, 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): UTI attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1_Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760. Ö σ, Records. Division of Vital Hospital or Attending within 2.

000033436 3/32/16/430 ph Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number 10069415 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee 500 U dward pperChesapeake

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MADELINE DENISON JENKINS ROHLFS March 24. 11:02P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Roland Park Place Baltimore None 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9 Birthplace (State or Foreign 1 - M 2/X Months Days Hours Jul 10122 ay 917 |229-03-8863 92 Director Maryland Usual Residence of Decedent show should be filled within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1XX Yes 2 No Maryland None Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 830 West 40th Street. 21211 USA 12. Was Decedent Ever in U.S. Armed Forces 1 1 Yes 24 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 Black, White, etc. \$ ☐ Never Married 2 ☐ Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 1 Yes XX No Specify: 3 Widowed 4 □ Divorced Specify: Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |Charles Dimmock Jenkins Madeline Denison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st of Health a item 27 is 1500 Westbrook Court # 4116 Richmond Virginia 23227 Charles Dimmock Jenkins **Brother** 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Burial 2 XXCremation 3 Removal from State GreenMount Crematory March 25,2010 Baltimore, Maryland 4 Donation 5 Other (Specify) uture of Funeral Serv 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ apmen TLA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 No a 🗌 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the period of the period of the detection of the detection of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of the period of 23e. Did tobacco use contribute to the cause of death? þ + VACT Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 140 Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 🗆 No Hospital: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35107

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Registrar

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31. Date filed (Month, Day, Year)

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40th Stred Balhmore mary

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Dun m.D.

MAR 26

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 20/0 March an/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) 04-01-1976 Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours 33 217-19-7065 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r items 23a or 20a-. 28a-f show 1 Yes X No Director Harford Bel Air MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 1530 Sunswept Dr 21015 USA Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No 11. Marital Status 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify. þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Banking Financial Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ann Lesniewski Robert Stumptner ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1530 Sunswept Drive Bel Air, MD 21015 Heather Stumptner (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of P
Important: If ite
any injury or ot
once. 1 XBurial 2 Cremation 3 Removal from State Bel Air Mem. Gardens 03-26-2010 Bel Air, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc 610 W. MacPhail Rd BelAir, MD 21014 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition BRONCHIOLITIS Obliterans Physician /Medical resulting in death) Due to (or as a consequence of) Examiner GRAFT VERSUS HOST DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 70 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner Hospital: 1 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 Yes 2 No eral Director: Ai filled in by the fu 2 Accident Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide City or Town, State) within 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item/23a) (Type, Print)

CHRISTIAN FREDERICK MFYFR 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 05:55 AM EO STAVIS MARCH Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Novemmber 20, 1921 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) 1 🔀 M 2 🗆 F Months Days Hours **Director** 88 Yrs 213-18-3630 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Dundalk Maryland Baltimore 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 21222 **USA** 1607 Leslie Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 XMarried Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Divorced 4 Divorced Completed White er than "natur , the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel 10 years Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) a 1 and 2 should be filed of Health and Mental H if item 27 is marked ot ir other traumatic ever Mary Mazeika Michael Stavis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 Leslie Road, Dundalk, Maryland 21222 Thelma E. Stavis wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 29, 6 Department of Important: If it any injury or o N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Baltimore National 2010 |Baltimore, Maryland Signal re of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers <u>Point Road, Dundalk, Md.</u> WINDA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pheumonia disease or condition resulting in death) Medical Due to ( as a consequence of) **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bacteremia, Cellulitis, Congestive Heurs Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Obstructive renal failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ☐ Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of **d**ertifie 29c. License number of my RES-000 MARCH 25,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar ROGER

31. Date filed (Month, Day, Year)

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BALTIMORE

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 1 1 1 9 3 2 State of Maryland / Department of Health and Mental Hygiene

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Aedical Exam	mer	Isabelle Cathe		ter	Lab	. City, Town, or	r I ocation o	of Death	March 22		. County of	Death	2030 hrs
		9648 Alda Drive	et and nambory			Parkville	Location	or Death			Baltimore		nty
Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birth	nday)	If Under 1 Yea		er 24Hrs.	4				hplace (State or
Director		212-38-2556 _{1 M}	2X F	68	Yrs.	Months Day	s Hours	Min.	Aug.3	31,1	941	Cou	n _{Intry} Marylar
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Aaryland 28a-f show 1 at once.	ctor	10e. Street and Number	716			10f. Zip Code	TIG			Ina Citiz	zen of What	Coun	
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136 hin 72 e. than '	omplete	12	college (1-4 or 5+)		Banl	c Tell	er			Ва	nkin	g	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Соп	17. Father's Name (First, Middle, Last)					18.Mother	's Name (	First, Middle,	Maiden S	Surname)	-	
21215-0036 hould be filed within 7/ ad Mental Hygiene. Is marked other than tite event, the Medical	Be	James Morgereth							le Sta				
O 21 should nd Me is man	To	19a. Informant's Name/Relationship (Type, F		19b	. Mailing A	ddress (Stree	et and Num	ber or Ru	ral Route Nur	mber, Cit	ty or Town,	State,	Zip Code) Maryland
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygers than the Mental Hygers and the Histly and Mental Hygers and the Histly and will Histly and ricens 23a or 28s-f she on other traumatic event, the Medical Examiner must be notified at once		Matthew Slater-so		Oh Place of	f Disposition	on (Name of ce	metery I		Date		ocation - C		
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 Burial 2 Cremation 3 Re	mount from State	cremato	ry or other				9,2010	i		•	Maryland
Baltimo permit. Page Department o Important: injury or oth		4 Donation 5 Other Specify:  23. Signature of Funeral Service Licensee		Cem	eterv	ne and Address		,					-
Balti permit. Departr Import		-ondrai L. M. For	John		Eya	ns Fune 0 Harfo	ral C	hape	l and	Cren	nation	ı S€	ryices
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each line		ath. Do not									Approximate Interval Between Onset and
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Division al or Attendir rs after death. al Director: Aled in by the fu	icat	2 Accident Investigation	8e. Place of Injury - A	At home, far	m, street,	factory, office b	uilding, etc	. 2	8f. Location (	Street an	nd Number o	or Rura	al Route Number, City
Div	Certification:	Suicide Could not be	Specify)	·			•		or Town, S				_
Hosp 24 hos Fune		29a. Certifier 1 Certifying Physician: To	o the best of my know	rledge, deat	th occurred	at the time, da	ate and plac	ce, and d	ue to the caus	se(s) and	manner as	stated	d.
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Direct After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical		ne basis of examinatio manner stated.	n and/or in	vestigation			curred at t	he time, date				
	Σ	29b. Signature and title of certifier	A 0000	10		29c. Licens							h, Day, Year)
		car of it	ucce			O.C.I	VI. ⊏.			Marc	ch 23, 20	10	
		<ol> <li>Name and address of person who completed</li> <li>Carol Alian, MD Assistant M</li> </ol>	eted cause of death (It edical Examiner		Penn Str	eet, Baltime	ore, MD	21201					
S	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign				,	,					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 0855 larence Smith 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore -8 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2□ F 53 220-68-4563 Director March 1, 1957 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore MD Director 1 XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21217 1510 Leslie Street USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Xes 2 □ No Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō If Yes, Give Year or Dates: US Army 1 ☐ Yes 2 No Specify. Specify: Black ģ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Trade Merchant Seaman 12 2+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Brown Clarence Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1510 Leslie Street, Baltimore, MD 21217 19a. Informant's Name/Relationship (Type. Print) of Health Penny Seymour / Sister Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages nent of I Department of Important: If Its any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/26/2010 Woodbine, MD Final Journey Crem. 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility}
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Dorota, Marshall Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Progressive Multiford **Physician** Leukoencephalopath disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner guired Immue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): executed burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician ned for use as the buria requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a P.O. | ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 3 ☐ Unknown should Completed been Were autopsy findings available prior to completion of cause of death? 24a. Was an The law cate has l autopsy perform After this certificate 2 🗆 No 1 ☐Yes 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division the Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the fu 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year, 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day,

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och RAVEN Blud. Ba HO, Md 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09331 State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2010 Lillian Mae Shipferling 11:10AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Center Baltimore 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 🗆 M 2 🗶 F Months Days Hours 216-01-3496 92 Director Yrs October 28, Maryland 1917 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 28a-f 1 X Yes 2 □ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 6300 Laurelton Avenue 21214 United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. Examiner Black, White, etc. δ 1 Never Married 2 X Married Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. White "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Department of Health and Mente Important: If item 27 is marked any injury or other remonents. ပ Sebastian Roehm Elizabeth Geyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Shipferling - Spouse 6300 Laurelton Avenue, Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Parkwood Cemetery March 26,2010 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services —
8800 Harford Road, Parkville, Maryland 21234 Parkville 23a. Part 1. Eight the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on real failure List only one cause on each line.

Immediate Cause (Final Hypertensive Heart Disease) Approximate Interval Between Onset and Death Hypertensive Heart Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Morre than **Examiner** Dementia one year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No 1 Live Birth
4 Pregnant a
9 Unknown ate has been signed by the atte page 2 should be detached for Pregnant at time of death Month Day Year 1 L Yes 2 Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 2 **N**O 1 🗌 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **K** No Other: ပ 1 Yes To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this ( 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D30681 March 24,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd., Baltimore, Maryland 21239 31. Date filed (Month, Day, Year) 32. Regis ar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** VLASTA VALCIK MARCH 25, 2010 0050 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Hours 216-12-5418 90 JULY 5, Director 1919 Czechoslovakia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be mailtied at Director 1 ☐ Yes 2 XNo Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 Long Bar Harbor Road 21.009 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3/25/10 005C Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mathew (nmn) Pavelka Anna (nmn) Kerakova 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra <u>Jerry F. Valcik / Husband</u> 711 Long Bar Harbor Road, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3-29-10 tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cokesbury U.M. Church Cem. Abingdon, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility
McComas Funeral Home, P.A. McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingo

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final 11 octs **Physician** disease or condition resulting in death) days /Medical Due to (or as a consequence of): Cerebral artery Stroke Examiner meddle sequents y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ettending physician and for use as the burial-transit atrial Librilaton resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No o. detached 9 Unknown 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy this certificate 1 ☐ Yes 2 HNO 2 No of Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOCUPPER Chesapeake Dr Bel Our MD 21014 800 31. Date filed (Month. 32. Registrar's Signatu State MAR 26 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09333 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day STELLA DEAN WAGONER Medical anc Examiner 4a. Facility Name (if not institution, give street and numb Town, or Location of Death 4c. County of Death more If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) WV 7. Age (In vrs. last birthday) **Funeral** 1 M 2 K F Months Days Hours JULY 26 Director Yrs 218-22-4684 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ₹ Yes 2 □ No MD BALTIMORE 5 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 items 23a 901 N. KRESSON ST 21205 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 6 þ 1 Never Married 2 Married Yes 2 No filed within 72 hours after Maryland 21215-0036 Specify: WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12TH **HOMEMAKER** HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ pe other traumatic WALTER V. LITTON ZELPHA RICHARDSON Page 1 and 2 should in ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 i HELENE WAGONER/DAUGHTER KRESSON ST., BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 4 Donation 5 Other (Specify) AIR MEM. GARDENS 03/26/2010 BEL AIR, MD. Signature of Funeral Service Licenses 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. any in 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disease, or o omplications that caused the delay one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ metastatic Ovarian Cancer 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? chronic renul failure 24a, Was an has autopsy performed? Yes 2 No After this certificate Diabetes 1 Yes 2 No To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Inpatient 2 FR/Outpatient 3 I DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the firme, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) DOC6 2689 march 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

FIFTER

Registrar's Signature

31. Date filed (Month, Day, Year)

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UNK UNK		State of Maryland / Department of Health and Menta	al Hygiene	2011	1 0933
ETTREY		1- For State Certificate of Death		Reg. No.	
Physici		1. Decedent's Name (First, Middle,Last)	Date of De     Month	ath Day Year	3. Time of Death
Medical Exami	ner	Jeli / E y	March 22	2, 2010	0250 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of University Hospital  Baltimore	Death	4c. County of Deat	/4
			out la Balance	10	// \
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	Min. 8. Date of B	irth(MM/DD/YYYY) 9. Bir Forei	
Director		218.08.1914 12M 2 F 28 Yrs. Months Days Hours	0122	-3/20/1982 co	untry)
ž.		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location			
* *		10a. State 10b. County 10c. City, Town or Location Baltimore			10d. Inside City Limits 1 Yes 2 No
/land -f she	ğ				<b>/</b>
Mar r 28a	Director	10e. Street and Number 10f. Zip Code 21229	a	10g. Citizen of What Cou	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once			1		
th wi	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		<ul> <li>14. Race - Amer</li> <li>White, etc.</li> </ul>	can Indian, Black,
or it	ᇍ	1 Yes 2 No		DI/	ick
s afte iral",	≦	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15 December 5 Februaries (Specific Selection Section 2) 15 December 5 Februaries (Specific Selection Section 2) 15 December 5 Februaries (Specific Selection Section 2) 15 December 5 Februaries (Specific Selection Section 2) 15 December 5 Februaries (Specific Selection 2) 15 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 December 5 De	1.6	орссиу.	
hour hour	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)		16b. Kind of Business/	
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1 with	Completed		Name (First, Middle,	Maiden Surname)	
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21215-0036 uld be filed within 72 hours after Mental Hygiene, marked other than "natural", c event, the Medical Examiner.		19a. Informaht's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number			Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner, must be notified at once.	-1			oad Balto	
and and Health		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)	3/30/10	Baltimon	e ND
ti. Pa	-	Bornation of John Specify.	- 1 1		
Bal Permi Depar Impo injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8728 Liberty	vaugnn c	. greene tur	reval services
Physician		23a. Part I. E tel the disease, or complications that caused the death. Do not enter the mode of dying, such as			Approximate Interval
/Medical	- 1	failure. List only one cause on each line.			Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			) Dodan
	- 1	Sequentially list conditions, b			
	힐	if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Ulsiass or injury that initiated expents resulting in death) Last  Due to (or as a consequence of):			
ted Insit		events resulting in death) Last Due to (or as a consequence of):  d.			
OX 68760, and certificate be executed attending physician and or use as the burial - transit	g	LINDENDED			
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876 tifical ng ph	<u></u>	23b. Was decedent pregnant in the	regnancy	23d. Date of delivery Month	ay Year
x 6 th cer trendi	18	4 Pregnant at time of death 5 Other (Specify)			
BOy e death the att	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown			
P.O. Be that the de ned by the detached fi	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I		obacco use contribute to	
P.C.	D D		1 Ye	s 2 V No 3 Prob	ably 4 Unknown
rds	Completed		24a. Was autor		opsy findings available ompletion of cause of
eco ne lav te has	틹			rmed? death?	`
A. III. T. D. III. P. D. III.		25. Was case referred to medical 26. Place of Death (Ch		2 10 10	S 2 NO
Vital Records, sysician: The law requirthis certificate has been director, page 2 should	B B	examiner?		Residence 6 Other	
of v	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	
Division of N Hospital or Attending Ph, 24 hours after death. Funeral Director: After titely filled in by the funeral	Certification:	1 Natural 5 Pending Mar 22, 2010 0210 hrs 1 Yes 2 ✓ No	Passenger	auto fixed object co	llision
riSi r Atto er de irecto	낊	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (	Street and Number or Rui	al Route Number, City
Div	핗	Suicide 6 Could not be determined (Specify) Local Street	or Town, S 5000 block B	State) altimore National Pike	Baltimore, MD
Hosp 24 hou Fune ely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	, and due to the caus	se(s) and manner as state	d.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr			
5.25.3	Me	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mon	th, Day, Year)
		hy hi, wo		March 22, 2010	
	ŀ	30. Name and address of person who completed cause of death (Item 23a)		<b>L</b>	
V 0)		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
	ate	31. Date fled (Monte) (April 20) Service 32. Registrate Signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a signal and a s			
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AMEND ITEM#IPERPHYS, G902, 4/28/2010, WS

State of Maryland / Department of Health and Mental Hygiene 2

1- State amend item 8 per th g903 5-4-10 vt

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Frank Huber 3. Time of Death Waltz, Jr, **Physician** Day Frank Hubert ам March 21, 2010 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurelwood Care Center Elkton Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. Mac (Jonth, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 191-22-7600 1 □ M 2 □ F 82 Director PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show MD Cecil Elkton Director 1 ☐ Yes 2√☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Laurel Drive 21921 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰es 2 □ No US Navy If Yes, Give 1945-46 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) d other than "natural", or Items event, the Wedest Exer, the F. 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Gas Tester Oil Refinery 12 4 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fil Health and Mental F tem 27 Is marked otl Be Frank Waltz Sr. Helen Brannon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tro phylis J. Anderson/Daughter 3550 Goodwyn Road, Powhatan, VA 23139 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crem. 3/24/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall

Maryland Cremation Services
PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** WNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner END STAGE WILD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit AMB requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical DEMONTO IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) P.O. hed by the detached 9 Unknown signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably A Conknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy certificate performe 1 ☐Yes 2 ☑No Division of Vital 1 □Yes Hospital or Attending Physiclan: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu death. 1 ☐ Yes 2 No 2 Accident investigation 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determines 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and hije 29c. License number 29d. Date signed (Month, Day, Year) 72 MARIO 30. Name and address prerson who completed cause of death (Item 23a) (Type, Print) ARLOW STORE MENARK DE 19713 ONE CENTURISM DR Sulte los 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 26 2010

DHMH 17 Rev 1/2001

			For 1 _ State	State of N	/larylar	-	rtment of F			ental Hy	•	001	0	000	20
			Registrar  1. Decedent's Name (First, Middle,	Last)			inicate or	Dean		2. Date of D	Reg. No	201	U_	3. Time of De	eath
	Physicia		Christopher	,	rt					March	24, Da	^y 2010 ^Y	ear	4:08	ам
	/Medic		4a. Facility Name (If not institution,				4b. City, Town, o	r Locatio	n of Death		_	4c. County of Death			
			136 Spring Pla	ace Way			Annapo				Anne Arundel				
П	Funeral			5. Sex 7. / 1 🛣 M 2 🗆 F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Und Hours	er 24 Hrs. Min.	8. Date of B	rth ay, Year)	9	. Birthp Coun	lace (State or F etry)	oreign
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Jand	MOI TE		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						11	0d. Inside City I	Limits
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181 y and 2 12 13 0000	ital Hygiene. d other than "natural", or items 23a or 28a-f show event, tre Modical Exemplar must be molified at	Funeral	11. Marital Status	12. Was Deceder Armed Force:	s?	.S. 13. \	Vas Decedent of H Yes, specify Cub	lispanic ( an, Mexic	Origin? (Spe can, Puerto i	cify Yes or N Rican, etc.)	0-	14. Race - Black,			
Te aff	P. (2)	by F	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 21 If Yes, Give Year or Dates		1	□Yes 2⊠No	Speci	ify:			Specify: V	Mhit	.e	
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	d oth	Be	17. Father's Name (First, Middle, La	ast)				18. Mo	ther's Name	(First, Middle		,			
y io	d Mer narke	은	Herb Weichert			Т			Eleano		ffit				
12.84	th and 7 is n traun		19a. Informant's Name/Relationshi				g Address (Street							•	
1 and	Heal em 2 other		Carol L. Weiche	rt, Wife	20b. I		Spring P			Annap		. Mary .ocation - Ci			<u> </u>
Pages	t: If It		1 ☐ Burial 2 🔀 Cremation 3		e		sition (Name of natory or other place matory ,			/2010				Marylan	A
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			23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplications that caus	ed the deat	th. Do not ent	er the mode of dyi	ng, such	as cardiac o	r respiratory	arrest,		7	Approximate Interval Betwe	en
PI	nysician		Immediate Cause (Final disease or condition	my one cause on each	iiile.	M	elano	MI	a					Onset and De	ath
•	Medical		resulting in death)	Due to (or a	as a consec	uence of):							1	1 44,	
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t See	attending p for use as	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnanc	04/				23d. Date			
Attending Physician: The law requires that the death certifi	he at	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnan 9 ☐ Unknowi	t at time of		Other (specify)					Monti	1	Day Yea	ar
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ires t	signed be det	by	Part II. Other Significant condition	is contributing to death	i but not res	ulung in the ur	ideriying cause giv	ven in Pai	rt I.					ne cause of dea pably 4 ☐ Uni	
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he lay	cate has	Completed								24a. Wa aut	s an opsy formed?_	pri	ere auto or to co oth?	psy findings av mpletion of cau	allable ise of
	certificate rector, pag	ပိ	25. Was case referred to medical					ne Di	and of Dooth	1 □ Yes	2 <b>3</b> N	0 1 [	Yes	2 No	
/sicla	this certificaral director, I	00	examiner?	Hospital:	atient 2	ER/Outpatier	t 3 DOA Oth			n <i>(Check only</i> me 5 <b>2</b> Re		6 □ Other	(Canail	54)	
2 E	ter thi	n: To	27. Manner of Death	28a. Date of I		28b. Time of Injury		ry at		28d. Describe			(Specii	,,	
algin a	or: Af	atio	1 Natural 5 Pending 2 Accident investiga	tion	Jay, Ibai)	Injury		Yes 2	□No						
r Att	ter de irecto irecto irecto	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determin	ed 28e. Place of building,	njury - At h etc. (Speci	ome, farm, stre	eet, factory, office		2	28f. Location City or To	(Street a	nd Number te)	or Rura	ıl Route Numbe	<i>∋r,</i>
ital c	urs af gral D		20-0-17												
To the Hospital or	within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical		Physician: To the be xaminer: On the basis and manner	of examina										
o the	omple	Mec	29b. Signature and title of certifier	and manner	stated.		29c. Licens	se numbe	er		29d. D	ate signed (	Month,	Day, Year)	
<u> </u>	> == 0		> 4 Lelo	uccli, l	w		DI	90	38		(	3. 21	1-		
			30. Name and address of person w	ho completed cause o	f death (Ite	m 23a) (Type.	Print)	V 2		<u> </u>	^	07		0	
			Stuart E.S	selouici	K, U	10 0	100 B	est	gate	Kd.	H	nna	001	is, un	a.
	Sta		31. Date filed (Month, Day, Year)	32. Regi	strar's Signa										
	Registr	ar	MAR 26 2010	General	A. ,	park	/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Ernestine Walker 2010 :50P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayviwe Baltimore n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min. Country) 217 58 9886 Director 56 Мау 95 Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director MD n/a Baltimore Y Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 801 S. Fagley St. 21224 USA items within 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 🗶 ☐ No Specify: If Yes, Give Year or Dates "natural", Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unemployed llth Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ရ Ernest Walker Thelma Barksdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Melvin Holley, Jr 911 Lemmon St. Balto, Md. (son) 21223 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🗌 Burial 2 🚾 Cremation 3 🔲 Removal from State cemetery, crematory or other place) Mar Green Mount Crematory 4 Donation 5 Other (Specify) Balto, Md. 21. Signature of Funeral Service License calvin B. Scruggs Funeral Home St. Balto.Md E Preston 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Jeath. Carcinoma 44 amous 0 disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မှ ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Many of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending death. 1 🗌 Yes 2 🗌 No Accident Investigation filled in by the hours after deat ineral Director; Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыете

State Registrar

DHMH 17 Rev 7/2009

within 2

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of certifier

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

700

31. Date filed (Month, Day, Year)

29b. Signature and title

Baltimore

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

003389

21224

29d. Date signed (Month. Dav. Year)

2010

MD

03

Kober

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

			For State Registrar	State o	f Marylar		artment of <i>rtificate of</i>				giene Reg. No.	2010	09338
	Dharisi		1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Gertrude &	lizabet	h W	est				March	,	3 2010	10:05 AM
	Examin		4a. Facility Name (If not institution, g	ive street and nui	mber)		4b. City, Town,	or Location	of Death		4c. C	County of Death	
esc. j			3530 GREENSPRI	IG AVE.			BALTI					N/A	
	Funeral		Social Security Number     6.	Sex 1 □ M 2 💢 F	7. Age (In yrs.		If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Birth (Month, Day	y Year)	9. Birthp	lace (State or Foreign
	Director		215-32-2747	1 W 2 M	80	Yrs.				9-21-1		l l	YLAND
	and and		Usual Residence of Decedent  10a. State 10b. County		10c, Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
	Maryl f sho	ō	MD. N/A			BALTIM	ORE						1 ☐ Yes 2 ☐ No
	the 1	Director	10e. Street and Number				10f. Zip Code				10a. Citiz	en of What Cour	itry?
	3a or	0	3530 GREENSPRIN	IC AND				1			Ü		,
	ms 2	Funeral	11. Marital Status		edent Ever in U	.S. 13. \	2121 Was Decedent of fYes, specify Cu		rigin? (Spec	cify Yes or No-		JSA 4. Race - Americ	an Indian.
٥	or Ite		1 ☐ Never Married 2 ☐ Married	Armed Fo 1 ☐Yes If Yes, Gi			_			lican, etc.)		Black, White,	
ვ	72 hours after death with the Maryland natural", or Items 23a or 28a-f show Steal Examiner must be rediffed at	l by	3 Widowed 4 Divorced	If Yes, Giv	ve" ates:		I∐Yes 2√∑No	Specify.	/:			Specify: BLA	CK
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	be fi	Be	17. Father's Name (First, Middle, Las	(T)						(First, Middle,		Surname)	
Š	d Me nark natic	မ	JOHN HARVEY						_	CE KENN			
Z Z	th and the and the and traur		19a. Informant's Name/Relationship  ROBIN BAILEY (Relationship)			1						Town, State, Zip	<i>'</i>
a)	1 and Heal em 2		20a. Method of Disposition	MOGRIEK	20h I					BALIII.		MAKY LA	ND 21211
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than." natural", or Items 23a or 28a-f show amportant: If Item 27 is marked other than." attural", or Items 23a or 28a-f show ampi injury or other traumatic event, the Madical Examiner must be rediffied at once.		1 Surial 2 Oremation 3		State		sition (Name of natory or other pi	i				•	
апшо	artme ortan injur	1	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice				MEMORIAI  Name and Add	ress of Facili	3-27-	2010  S	YKES	VILLE, I L HOMÉ,	MARYLAND
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			23a. Part 1. Et er the disease, or co	mplications that c	aused the deat							IL PIARI	Approximate
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	tospit 1 hour uners ely fille		29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical Ex	Physician: To the	best of my kno	owledge, deat	n occurred at the	time, date a	and place, a	and due to the	cause(s)	and manner as s	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	uney	and man	ner stated.								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician**  $A^{M}$ Mae Zivkovich 26, 2010 8:10 Frances March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1963 Holborn Road Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) October 5,1941 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 M 2 XF 217-38-2406 Director 68 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Exeminar nust be notified at 1 ☐ Yes 2 👿 No Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 USA 21220 3505 Buckboard Lane permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Experience once. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Roller Mill Buyer 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Perseghin Una Mae Lee ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony J. Zivkovich HUsband 3505 Buckboard Lane, Middle River, MD. 21220 March 29 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛛 Burial 2 □ Cremation 3 □ Removal from State Stanislaus Cem. 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Connelly Funeral Home Of Dundalk, P.A. ature of Funeral Service Licenses 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, shock, or heart failure. e, or complications that cause, the death. List only one cause on each ine. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, mmediate Cause (Final **Physician** disease or condition resulting in death) Month /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): physician P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 mont Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ZNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cate has been signal page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 🗆 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1□Yes 2□Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this hours after death.

Ineral Director: After this

y filled in by the funeral di 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the and manner stated 29b. Signature and title of co 29c License 29d. Date signed (Month. Day. Year. completed cause of death (Item 23a) (Type Print) 30. Name and address of

State

Registrar

31. Date filed (Month, Day, Year)

MAR 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland / Department of Health and Mental Hygiene ar Certificate of Death Reg. No. 1 - For State Registrar Beg. No. 1. Decedent's Name (First, Middle, Last) Zabludoff 2. Date of Death Esther Day 2010 **Physician** MARCH 17, 5:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7218 PARK HEIGHTS AVENUE, #101 PIKESVILLE BALTIMORE 8. Date of Birth (Month, Day, Ye. 7/18/1917 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 M 2 N F Days Hours Min. Months 92 185-01-0240 Director Usual Residence of Decedent 1∩a State 10h County 10c. City, Town or Location 10d. Inside City Limits death with the Maryla 28a-f show 7 Is marked other than "naturel", or items 23a or 28a-f shov traumetic event, the Medical Exercity regard by notified at 1 ☐ Yes 2 No Funeral Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7218 PARK HEIGHTS AVENUE, #101 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ( No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify. þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumetic event security." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** BOOKKEEPING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS NATHANS IDA REBALSKY ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRIAM Z. HAAR/DAUGHTER FALLING BROOK COURT, OWINGS MILLS, MD 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State HAR ZION CEMETERY 3/18/2010 PHILADELPHIA, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD INC. 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). requires that the death certificate be executed the burial-trans Due to (or as a consequence of): Box 68760. physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) P.0. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à icate has been si , page 2 should t 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate | performed' 2 No Division of Vital 1 □ Yes 2/1No Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the ft 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MAR 2 6 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who comple



ause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

5

1 ☐Yes 2 ☑ No

Approximate Interval Between Onset and Death

Year

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Denve S. parke **ORIGINAL** 

Vikramaditya Poonai M.D. 924 Seton Drive Cumberland MD 21502

29c. License number

D36766

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ical Examin		4a. Facility Name (if not institution, give street and number)	4b. C	ity, Town, or	r Location of		naich 20, 2	4c. County o	Death	
		Doctor's Community Hospital	La	nham				Prince G	eorge'	s
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday) If	Under 1 Yea	ar If Under	24Hrs. 8	. Date of Birth	(MM/DD/YYYY)	9. Birth	place (State or
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MD 12 sho 17 is 127 is unmat		Jean Agostinho (Mother)	8326 Va	rona S	St. Ne	w Car	rollto	n, MD	2078	34
Te, Land			crematory or other r	lace)						
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0		<ol> <li>Name and address of person who completed cause of death (Iten Margarita Korell MD. Assistant Medical Examin</li> </ol>		Street	Baltimore	MD 21	201			
10		21 Date filed (Month, Day Year) 32 Registrar's Signat	ture .							
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AMEND TTEM#10a-c.e.f.perFH.G909.11/30/2010 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** V10/9 2.15 AM 03 09 2010 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Marlboro Pike Mho If Under 1 Year | If Under 24 Hrs. Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 924 1 □ M 2 🔀 F Months Days Hours Min. N. Carolina 85 216-70-4491 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expraise Traust be retified at once. 10a. State 10b. County Franklin 10c. City, Town or Location
Louisburg
Millersvi 10d. Inside City Limits Director 1 ☐ Yes 2 No Anne Arundel 27/ Vaiden Rd. 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐YNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Housewife N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lottie Perry Sylvester Burt Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Aytch (Son) 8190 Weyburn Rd. Millersville, Md. 21108 20a. Method of Disposition 20c. Location - City or Town, State 20b. Blace of Dispestion (Name of cemetery crematory or other place) Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 3 - 20 - 10Annapolis, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Miniame Removes of Collisions Mortuary, 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Cardiopulmunary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Dertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ned by the attending physician and detached for use as the burial-transit Diabetes mellitus Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 1 □ Yes 2 No 2 **N**O r this certificaral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. investigation 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature an e of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/10/10 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24 UBSHILIGHON DC

DHMH 17 Rev 1/2001

State

Registrar

**SOUTHERN** 

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BAHRAM 31. Date filed (Month, Day, Year) MD

32. Registrar's Signature

36

Aue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day rand 2010 935 PM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Ye June 23, 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F 86 Months Hours Year! 219-12-3785 Director 1923 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 Wo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21401 Funeral 231 Cape St. John Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married **XX**Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: Year or Dates. 1942-46 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Repairman Telephone Company 12 Be 17. Father's Name (First, Middle, Last)
Richard Bradley Alvey 18. Mother's Name (First, Middle, Maiden Surname) ပ Pauline Steele 19a. Informant's Name/Relationship (Type, Print)
Bradley H. Alvey/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2441 Yardley Court Waldorf, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mayo U.M. Church Cem. 3/15/2010 4 Donation 5 Other (Specify) Edgewater, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home Signatura o Funera TT 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Priysician/ disease or condition resulting in death) Cas Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death. Interctor: After this certificate has t d in by the funeral director, page  $2\,\,\epsilon$ autopsy performed Yes 2.2 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1- Natural injury 5 Pending 2 🗆 No Accident Investigation Suicide 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie ٩ 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bestgate Rd Sute 300 Amanily

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar

MAR 12 2010

10-02173 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Benjamin David Barber State of Maryland / Department of Health and Mental Hygiene 2010 09345 1- For State Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month **Medical Examiner** Benjamin David Barber 1350 hrs March 17, 2010 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Davidsonville 655 Governor Bridge Road 655 Governor Bridge Road 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Davs Hours 220-84-8947 1 M 2 F 09/28/1973 Country) Maryland 36 Usual Residence of Decedent any 10a. State 10b. County I0c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Davidsonville or 28a-f show Anne Arundel s 23a or 28a-f show Maryland hours after death with the Maryland rector 10e. Street and Number 10f. Zip Code 21035 10g. Citizen of What Country? United States 655 Governor Bridge Road Funeral 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Specify: White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: the Medical Examiner φ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) it. Pages I and 2 should be filed within 72. Irment of Health and Mental Hygiene.
rrtant: If item 27 is marked other than ", y or other traumatic event, the Medical E Baltimore, MD 21215-0036 H.V.A.C. Technician 12 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Paula E. Storinoff Be Robert W. Barber 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 655 Governor Bridge Road, Davidsonville, MD 21035 Robin Barber/Sister 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 03/20/2010 Edgewater, Maryland Kalas Crematory mportant: 4 Denation 5 Other Specify ^{22.} Name and Address of Facility George P. Kalas Funeral 2973 Solomons Island Road, Edgewater, N MD 21037 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and Medical Death a Oxycodone and alprazolam intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and be executed sician/Medical AMENDED 4a,23a,27,28a-f,perm,E G901 3/30/10 TT the attending physician are for use as the burial -X UNPENDED Box 68760. The law requires that the death certificate IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Month Day past 12 months? Pregnant at time of death 5 signed by the att 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed death? Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be ER/Outpatient 3 DOA

Division of Vital Records, P.O. the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certifi the

2 No Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Injury 1 Natural 1 Yes 2 X No 5 Pending Fd 3/17/10 Fd 1:30 pm Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 655. Governor Bridge d Davidsonville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be detached garage Homicide

O.C.M.E.

Year

March 18, 2010

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

Hallan 30. Name and address of person who completed cause of death (Item 23a)

> Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Mogth Pay Year) 2010 State Registrar

Certification:

Medical

Carol Allan, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 285 tate of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** nomas W /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joh Mar Baltimore Sex 1X M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Num 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 85 Director 178-24-6301 09 1924 04 Mahanoy City, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Waynesboro PA Franklin 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with thygiene.

Other than "natural", or items 23a or items 43a or items 43a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45a or items 45 ō 17268 US 13163 Delaware Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

Armed Forces?

I No 1944

If Yes, Give 1944

Year or Dates: 194 Black, White, etc. 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. þ 3 Widowed 4 Divorced white 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) government program manager is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be the Health and Mental Agnes Konopka Florian D. Boczkowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13163 Delaware Circle Waynesboro, PA 17268 Linda S. Brent 27 Department of Health Important: If Item 27 any Injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 3/2472010 1 ☐ Burial 2 🌡 Cremation 3 🗷 Removal from State 17268 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Valley Crematorium Waynesboro, PA 22. Name and Address of Facility ure of Funeral Service Licensee Grove-Bowersox Funeral Home, Inc. ames & 50 S. Broad St. Waynesboro, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed CHRISTICATION APPROVED BY MEDICAL EXAM and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 5 Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by acture 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Physician: The certificate 2 □ No 1 □ Yes 2) 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending **Unknown** M 1 ☐ Yes 2 No investigation rall 24 hours after death. Funeral Director: / 2. Accident 7/2010 with hemor wallere filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide nome Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Haloner

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March

Baltimore

Amend 28b, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For ME 9902 415/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 1700 M 14 John Joseph Belota II lur ,2016 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 18808 Rolling Rd. Hagerstown Washington County 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 233-72-8357 63 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at Be Completed by Funeral Director Maryland Washington County Hagerstown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18808 Rolling Rd. 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 📉 No Specify: White If Yes, Give The Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "ne any Injury or other traumatic event and once. College (1-4or 5+) Elementary/Secondary (0-12) Office Manager Woodworking Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Belota Irene Oliverio Belota 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Belota-wife 18808 Rolling Rd. Hagerstown, MD 21742 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 3-16-2010 Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the lifease, or complications that y use: the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carhon disease or condition resulting in death) Man otile /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, a line to in modern included cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): P.O. Box 68760. Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Monknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Yes 2□No Medical Certification: To 28b. Time of **unk** 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 🗌 Natural 5 Pending Suicite- Chihan Monordo 17cm 14,2014 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 2 Açcident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 777 City or Town, State) 4 - Homicide Home 184081201 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19.01 Oschard tenas 13d. 1/ajers form, M:
strar's Signature 30_Name and address of person who completed cause of death (Item 23a) (Type, Print) d w. Dittomm 31. Date filed (Month 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Edward Thomas Borda 2010 2:25 Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Arden Courts Assisted Living Silver Spring Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Days Feb. 18 (1928 Hours 1X M 2 D F New York 100-20-5088 82 Director Usual Residence of Decedent or 28a-f shov 10b. County must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1612 Tilton Drive 20902 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc ö ģ 1 Never Married 2 Married Maryland 21215-0036 72 hours after Specify: White If Yes, Give Year or Dates, 1944-46 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 5+ should be filed with and Mental Hygier is marked other t Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Borda Elizabeth Roeso ge 1 and 2 should be nt of Health and Mer :: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan A. Borda/Wife 1612 Tilton Drive, Silver Spring, MD 20902 Baltimore, 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State ò March 11 Metropolitan Crematory Alexandria, Virginia injury 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service Licensee 27 Name and Address of Collins Funeral Home Inc. Francis Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 me Approximate
Interval Between
Onset and Death
5 vears 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Dementia, Alzheimer's Type disease or condition years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months?

1 Yes 2 XNo Month Day Year Pregnant at time of death the detached 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate Physician: director 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 K No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after decth.

To the Funeral Director After this a completed filled in by the funeral director. this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

MAR 12

2010

1541

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Armstrong, MD 14201 Laurel Park Drive, #102, Laurel, MD 20707

Registrar's Signat

D43237

March 11, 2010

			For State	State of I	Maryland /	•	rtment of H			0.0		20010		
	_		Registrar  1. Decedent's Name (First, Middle,	/act)	Dealli	2. Date of Dea	Reg. No.	111	3. Time of Death					
	Physicia	an	Margaret Rowena	,	a				Month	Day	Year			
1	/Medic		4a. Facility Name (If not institution,				4h City Town or	r Location of Deat	March	4c. County o		2:50 A [™]		
	Examin	er	Wilson Health C	•			•	rsburg		Montgomery				
	Funeral				Age (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthplac	e (State or Foreign		
	Director		230-16-7431	1 □ M 2 <b>%</b> □ F	88	Yrs.	Months Days	Hours Min.	(Month, Da)		Country	) Virginia		
	0		Usual Residence of Decedent						110/04/1					
	irylar show	<u>.</u>	10a. State 10b. County		10c. City, Tov	wn or Loc	ation				10d.	inside City Limits		
	e Ma Ba-f	앓	Maryland Montg	omery	Gai	ther	sburg					1 ☐ Yes 2 XNo		
	in the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	hat Country	?		
	ath w	ra	301 Russell Ave				20877			United				
	er de	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	Specify Yes or No- to Rican, etc.)	14. Race Black	<ul> <li>American</li> <li>White, etc.</li> </ul>			
36	s aft	S F	1 ☐ Never Married 2 ☐ Marrie 3 🕱 Widowed 4 ☐ Divorced	ed 1 ∐Yes 2[ If Yes, Give Year or Date		1	□Yes 2MNo	Specify:		Specify:	Whit	0		
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural" or items 23a or 28a-f show ent, the Modical Examiner must be notified at	Completed by	15. Decedent's			ia. Deced	ent's Usual Occup	ation		16b. Kind of Bus				
15	in 72 n "ne n "ne Medlic	plet	(Specify only highest	t grade completed)		(Give k	ind of work done of NOT use retired	during most of wor	rking	Montgom		-		
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<u>a</u>	should be and Mental s marked o umatic eve	고 B	William Craig					Eula B	ean					
ar,	2 shoi and h Is ma	-	19a. Informant's Name/Relationsh	ip (Type. Print)	19	b. Mailing	Address (Street	and Number or Ru		er, City or Town, S	State, Zip Co	ode)		
	1 and 2 Health a em 27 Is other tra		Craig A. Bond (	Son)		6805	Mount 0	live Cou	rt Centr	eville,	Virgi	nia 20121		
Baltimore,	S # # 0		20a. Method of Disposition		aamat	of Dispos	ition (Name of atory or other plac	e) Mar	ch 25	20c. Location - C	City or Town	, State		
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a	permit. Page Department of Important: If any Injury or once.		21. Signature of Funers Service L	icensee		22.	Name and Addres	10.00 At 0.00 Mg		eral Hom				
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			23a. Part 1. Enter the disease, or of the chock or heart failure. List of	complications that cause	sed the death. Do						A	pproximate terval Between		
F	hysician	ĖΥ	Immediate Cause (Final disease or condition	Res	pera	to	yfai	lure			18	nset and Death		
	/Medical		resulting in death)	Due to (	as a consequence	e of):	00							
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)	and trans	am	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с						<del> </del>				
8760,	cate be executed ohysician and the burial-transit	û	resulting in death) Last	Due to (or	as a consequence	e of):								
87	icate be executed physician and s the burial-transit	dical	•	d							_			
9 : X	Ine law requires mat the death cerning tate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcor	me of pregnancy		-							
P.O. Box	eath atten for u	ian	23b. Was decedent pregnant in the past 12 menths?	1 Live birt	h 2 Fetal death		Ectopic pregnance Other (specify)	у		23d. Date Mon	of delivery th Da	ay Year		
o i	the d	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknow		2	Other (specify)							
٦.	res that the de signed by the a be detached t	H.	Part II. Other significant condition	ns contributing to deatl	h but not resulting	in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contril	bute to the	cause of death?		
Vital Records,	ures sign Id be	d by	Lyperten	sion.	Ostean	st	pridi	$\boldsymbol{\nu}$	1 🗆 Y	es 2 No 3	3 ☐ Probab	ly 4 🗌 Unknown		
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₹ :	ysician: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ■ No	Hospital:			Oth		ath (Check only or					
Division of	r this	Ë	27. Manner of Death	28a. Date of I	atient 2 ER/C	Jutpatient . Time of	3 LI DOA	4 LE Nursing F	1	lence 6 Othe				
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2	or Attency after death Director: In by the	fica	3 ☐ Suicide 6 ☐ Could no	ot ho	Injury - At home, t	farm, stre			28f. Location (S	Street and Numbe	r or Rural R	oute Number.		
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:	pspire hours inera y fille		29a. Certifier 1 Certifying	Physician: To the be	est of my knowled	ge, death	occurred at the tir	me, date and plac	e, and due to the	cause(s) and mar	nner as stat	ed.		
-	to the Prospital or Artending Prhysician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. p	Medical	(Check only 2 Medical E	xaminer: On the basi and manner	s of examination a	and/or inv	estigation, in my o	ppinion, death occi	urred at the time,	date and place, a	nd due to th	ne cause(s)		
	vith To t		29b. Signature and title of certifier		_		29c. Licens			29d. Date signed				
	8		* 14. Kabert	Buch	rach	MIL	1, 04	115	^	march	11,2	010		
			30. Name and address of person v	who completed cause of	of death (Item 23a	(Type, F	Print) 2011	PUSSEL	LAUEN M	ME 20	277			
	Sto	te	31. Date filed (MORTH Day, Year)	2010 37 Regi	istrar's Signature		ich.				/			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March 09 2010 Year Elizabeth Bartish 10:40a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 9604 Lorain Avenue Montgomery Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In vrs. last birthday) Days 1 M 2 X F Hours (Month, Day, Year) 11/04/1916 Director 152-10-7483 93 Ohio Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 🗶 No Montgomery Maruland Silver Spring 5 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral items 23a 9604 Lorain Avenue 20901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 6 1 ☐ Yes 2 🗷 No If Yes, Give 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Nursing Be 18. Mother's Name (First, Middle, Maiden Surnage)

Perigyi

Elizabeth

Perigee 17. Father's Name (First, Middle, Last) ည Vincent Sirback 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Catherine Davis-Daughter 9604 Lorain Avenue. Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Decremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 03/16/2010 Brentwood, Maryland 21. Signature of Fineral Service Lic 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring. MD 23a, Part 1. Enter the dise or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiorespiratory Failure Medical More than **Examiner** Atherosclerosis of Coronary Artery 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 X No Month Year Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Completed 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 **X** No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \foldsymbol{X} \) No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) eral Director; After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 🗓 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I only one)

State Registrar 29b. Signature and title of certific

MD,

Day, Year)

Nan Wang,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10801 Connecticut Avenue,

DHMH 17 Rev 7/2009

D0060233

Kensington, Maryland 20895

29d. Date signed (Month. Dav. Year)

March 11, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 8 2010 Year Badia Barbari 5:05p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Warm Hearts Home Germantown Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🖵 F Days 5/06/1925 214-78-0111 Palestine Director 84 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Wheaton 1 🗌 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 20902 11911 Dalewood Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc 2 should be filed within 72 hours are alth and Mental Hygiene. Completed by 1 Never Married 2 Married ☐ Yes 2**X** No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ₩Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nazar unknown George Eljamil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Elaine Iskandar/Daughter 18823 Poppyseed Lane Germantown, Md 20875 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Sp Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. 3/11/2010 Gate of Heaven Silver Spring, Md PHILIPADERINALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter ye disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he is failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MALIENANC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dile to (or as a consequence of, Exam and trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Pregnant at time of death Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X N certificate 2 🗌 No 1 Tes or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2X No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) hospice 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending death. 2 Accident 1 🗌 Yes 2 🗌 No irector: A by the fi Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Records, **Division of Vital** within 24 hours after
To the Funeral Direc To the Hospital of within 24 hours at To the Funeral D

> Deborah Belsky MD Year) State Registrar

and title of certifier

30. Name and address of person who completed cause of reath (Item 23a) (Type, Print)

29b. Signatur

Connecticut Ave. Kensington, Md 20895

10810

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) March 10,2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D58380

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month Sandra Lee Baker 2010 1847 Medical Малсһ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Center Upper Chesapeake Medical Harkord 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 XF Months Days Hours Min. **Director** 220-52-3245 Virginia Usual Residence of Decedent or 28a-f shov 10a. State 10b. County traumatic event, the M-dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Harkord Havre de Grace 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 214 South Washington Street U.S.A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 'n, Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give White Specify. "natural", 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manukacturina Factoru Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be f John Francis Showalter Mary Sue Rake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other tra Donald Lee Baker (Husband) 214 S. Washington St., Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Mem. Gdns Aberdeen. Maryland 03/17/2010 22. Name and Address of Facility Zellman Funeral Home. P.A. 123 S. Washington St., Havre de Grace, MD 21078 23a. Part 1. Ent. He disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) da Medical Due to (or as a con uence of): Examiner ABDODIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or) for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed ur EK and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the secompleted filled in by the funeral director, page 2 should be detached it 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ONGESTIVE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 013esira 24a. Was an 100010 Sandra autopsy performe 1 Ves 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work? 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death under distributions, date and place, and due to the cause(s) and marrier as stated To the 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) atr 66347 who completed cause of death (Item 23a) (Type, Print) Kapi Kumar 30. Name and address of person Patel, M.D HESAPEAKE 21014 31. Date filed (Month) State Registrar

March

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 24a per phys. G902 4/15/10 dk
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician**  $a^{\mathsf{M}}$ Betty Jean Bowie March 8, 2010 8:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Civista Medical Center Charles LaPlata 8. Date of Birth (Month, Day, Year) March 2,1937 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 215-36-4508 73 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ X o Director Maryland Charles Nanjemoy 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11405 Rainbow Place 20662 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 □Yes 2 □No Specify. ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress / Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas E. Bastain Violet C. Posey ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland Bowie Husband 11405 Rainbow Place, Nanjemoy, Md. 20662 20b. Place of Disposition (Name of cemetery, crematory or other place) March 11,2010 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Nanjemoy Baptist Church Nanjemoy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or heart disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or s consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vinknown After this certificate has been subnered director, page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X** No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 17No 1□ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MDINO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

ASHVINICUMA 31. Date filed (Month, Day, Year)

MAR 1 1 2010

Char

ORIGINAL

parks

Registrar's Signature

32.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	State of Maryland		t of Health and I e of Death		ene 1. No. 2011	1 00251		
Physi	cian	1. Decedent's Name (First, Middle, Last) Gladys	Beardsley			2. Date of Death Month March 9,	Day Year	3. Time-of Defath 1.3 5:15 PM M		
/Med		4a. Facility Name (If not institution, give st		4b. City,	Town, or Location of Death	-	4c. County of Death			
Ł		Genesis LaPlata		LaP1		8. Date of Birth	Charles  3. Date of Birth 9. Birthplace (State			
Funera Directo		5. Social Security Number 6. Sex 1	7. Age (In yrs. las	Yrs. Months		(Month, Day	1932 Sout	th Carolina		
ъ		Usual Residence of Decedent  10a, State 10b, County	10c. City.	Town or Location				10d. Inside City Limits		
Maryla -f sho	ģ	MD Charles		Tobacco				1 X Yes 2 □ No		
h the	Director	10e. Street and Number	1010	10f. Zip	Code	10	g. Citizen of What Co	untry?		
th witl		8270 Megan Lane		206			ited State			
5-UU36 72 hours after death with the Maryland natural", or items 23a or 28a-f show	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 L Mo If Yes, Give Year or Dates:	13. Was Dece If Yes, spe 1 ☐ Yes	dent of Hispanic Origin? (S cify Cuban, Mexican, Puert 2 X No Specify:		14. Race - Amer Black, White Specify: Wh	ite		
215-0036 thin 72 hours aff te. tan "natural", or	Completed	15. Decedent's Educa (Specify only highest grade	completed)	16a. Decedent's Usu (Give kind of wo life. DO NOT u	al Occupation irk done during most of wor se retired)		ndustry			
	omo;	Elementary/Secondary (0-12)	College (1-4or 5+)	Home Mak			Home			
	å	17. Father's Name (First, Middle, Last)				_{ne (} First, Middle, M Rice	aiden Surname)			
Marylan d 2 should be th and Mental 7 Is marked of	2	Claude Knight  19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailing Address	S (Street and Number or R		City or Town, State, 2	(ip Code)		
		Charles Beardsle	y Jr.(Son)	P.O. Box		bacco, MD				
# - I = #		20a. Method of Disposition  1 ☐ Burial 2 🂢 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ce of Disposition (Na netery, crematory or o tt <b>Cremato</b>	ry 3/1	1/2010 W	oc. Location - City or aldorf, MD			
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ds, P.  Jires that the signed by dispersed by the detaction.	۵	Tarti. Other organicant conditions som	tributing to death but not result	ing in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to s 2 ☐ No 3 ☐ P	o the cause of death?		
Division of Vital Records, to a transfer death.  I or Attending Physician: The law requires to after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be come in by the funeral director, page 2 should be come.	Completed					24a. Was ar autops perforn 1 ☐ Yes 2	/ prior to	utopsy findings available completion of cause of		
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g Physicar this leral dir	12	1 ☐ Yes 2 No H	1   Inpatient 2   E	28b. Time of Injury	28c. Injury at Work?		nce 6 ☐ Other (Spe w injury occurred	cuy/		
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Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in			sician: To the best of my knowner: On the basis of examinati	ledge, death occurre	d at the time, date and plan	ce, and due to the c	ause(s) and manner a	s stated.		
the Hc hin 24 the Fu	Medical	one) 2 Medical Examin	and manner stated.		9c. License number		9d. Date signed (Mon			
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BB	4	30. Jam a) address of pers n ho co	1 dupit	23a) (Type, Print)	). WAL	SORVY,	mel.	50903		
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	A ARICA						

		State of Maryland / [				•	3				
	1	State Registrar	Certificat	e of Dea		Reg.	No. 201	0.09355			
Physician /Medical	1	1. Decedent's Name (First, Middle, Last)  Robert Eugene Bourdeau			2.	Date of Death Month March	Day Year 5, 201	3. Time of Death 0			
Examiner	1	4a. Facility Name (If not institution, give street and number)  Laure Regional Hospital	4b. City,	Laur	1		4c. County of Death Prince George's				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir 022−12−4215 15√2 M 2□ F 88	thday) If Under Yrs. Months	1 Year   If Ui Days Ho	nder 24 Hrs. 8. urs Min.	Date of Birth (Month, Day, Yeeb. 1, 192		thplace (State or Foreign puntry) MASS			
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h with the 23a or 2		10e. Street and Number 7293 Browns Bridge Road	10f. Zip	Code 207	759	10g.	Citizen of What Co	ountry? USA			
urs after death wall, or items 23a		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Wes Secure 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New	1		c Origin? (Specif xican, Puerto Ric ecify:	y Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If tiem Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examinar must be incliffed at once.  To Re Commissed by Eumeral Director	Dataidino	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  4 College (1-4or 5+)	Decedent's Usua (Give kind of wor life. DO NOT us NASA	l Occupation k done during e retired)	most of working	166	Governmen	·			
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		23a. Part 1. Enter the disease, or commications that caused the death. Do shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death			
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Sepsi S  Due to (or as a consequence						<u> </u>			
Examiner	2	Sequentially list conditions, if any, leading to fining data cause. Enter Underlying Cause (Disease or injury	Lobe Pr	reumo	nid						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examiner	- T	Cause (Disease or injury that initiated events resulting in death) Last  C									
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yslcian is certif director	)	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/OL	utpatient 3 DO	Othor	Place of Death (C Nursing Home		e 6 ☐ Other (Spe	ecify)			
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To the within to the comp		29b. Signature and title of certifier	29c	License num			Date signed (Mont				
RA.		30. Name and address person who completed cause of death (Item 23a)	(Type, Print)	D55			The same of	2010			
UPIVA	-	Abdul Munim, MD Laurel Region 31. Date filed (Month, Day, Year) 32. Bygistrar's Signature	1 1 1	tal T	1300 Van	Dusen f	Rd. Laur	el, MD 20707			
State Registrar		MAR 10 2010 Server B.	park	,				* .			

		Pleas	e Type or Pri				-	•	).		
	-	For State Registrar	State of M	aryland / Depa Cea	artment of F rtificate of L		, 0	ene g. No. 201	0 0005		
Physician		1. Decedent's Name (First, Middle, L William H. Barr					2. Date of Death Month March	Day 2010	3. Time of Death 6:46 P M		
Medica Examine		4a. Facility Name (if not institution, g Mandrin Hospice	ive street and number) House			Location of Death	, iai oi	4c. County of Dea	Arundel		
Funeral Director		5. Social Security Number 088–14–1867	.Sex 1 ፟ M 2 ☐ F	e (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bi	rthplace (State or Foreign ountry) OW York		
faryland Ba-f show tified at	ector	Usual Residence of Decedent  10a. State  Maryland  Anne A	Arundel	10c. City, Town or Lo		napolis			10d. Inside City Limits  12 Yes 2 □ No		
with the h	Funeral Director	10e. Street and Number 2 Williams Driv	<i>7</i> e		10f. Zip Code	21401	10	g. Citizen of What C	ountry? • A •		
ter o	2	11. Marital Status 1 ☐ Never Married 2 ∰Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 X Yes, 2   If Yes, Give 1 Year or Dates.	No	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W			
within 72 hou giene. er than "natu , the Medical	Completed		cedent's Education highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accoustical Engineer Engin								
d be filed Vental Hygarked oth	To Be	17. Father's Name (First, Middle, Las William H. Bar				18. Mother's Name Josephin	e (First, Middle, Ma Ne J. McD	iden Sumame) ermott			
nd 2 should salth and N n 27 is me er trauma		19a. Informant's Name/Relationship Florence Fay Bar			ng Address (Street a		al Route Number, C polis, Ma	ity or Town, State, Z aryland	ip Code) <b>21401</b>		
Page 1 ar nent of He ant: If iten Iry or oth	- 51	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. Place of Dispo cemetery, cren Baltimore	natory or other place	e) !		oc. Location - City o			
permit. Departr Imports any inji		21. Signature of uneral Selvice Inco	ensee. L				_	lor Funera Annapolis	al Home , MD 21401		
Physician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line Prost	tate Cancer		g, such as cardiac c	or respiratory arrest	,	Approximate Interval Between Onset and Death 2 years		
Medical Examiner	_	Sequentially list conditions,		a consequence of): estive Hear	rt Failure	Failure					
ecuted and I-transit	Examiner	if any, leading to immediate  cause. Enter underrying  Cause (Disease or iinjury that initiated events  c.									
te be exer	_	resulting in death) Last	Due to (or as a	a consequence of):			_				
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	~ I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23d. Date of de Month	elivery Day Year							
luires that the signed by all be deta	ed by P	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.			o the cause of death?  Probably 4 🔀 Unknown		
Physician: The law rec r this certificate has bee aral director, page 2 sho							24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of		
ysician s certifi director	0 DE	25. Was case referred to medical examiner? 1 ☐ Yes 2XXNo	Hospital:	ent 2 ER/Outpatien	Otho	r:		HOS	spice House		
tending Phyeath.  or: After thi the funeral	cerillicate: 1	27. Manner of Death  1√√√√ Natural 5 ☐ Pending 2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not	28a. Date of injur (Month, Day	ry 28b. Time of	28c. Injury work?	at :	28d. Describe how		ally)		
ital or Ati urs after d ral Direct led in by t		4 Homicide determine		ry - At home, farm, stre . (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,		
the Hosp nin 24 hou the Funer	Medical	(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying No	nysician: To the best of miner: On the basis of exurse Practioner: To the l	kamination and/or invest	igation, in my opinio	n, death occurred at	the time, date and I	place, and due to the	cause(s) and manner stated.		
To t To t		29b. Signature and title of certifier	M	M	29c. License	number 0046303	290	I. Date signed (Mont March 9,			

State Registrar DHMH 17 Rev 7/2009

10+1

31. Date filed (Month, Day Year) 10 2010

pares

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marco A. Mejia, MD 2002 Medical Parkway Suite 310 Annapolis, Maryland 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	aryland	d / Depa	rtment of h	lealth a	nd Me	ental Hy	giene	00:0		
			State Registrar			Cen	ertificate of Death Re					Reg. No. 2010 0935		
	Physicia	ın/	1. Decedent's Name (First, Middle, Martha Eller	,					2	2. Date of De Month	ath Day	Year	3. Time of D	eath
	Medic	al	4a. Facility Name (if not institution,							03	10	2010	5:55	A M
1	Examin	er					4b. City, Town, or		Death			unty of Death		
	Funeral		5. Social Security Number 6	7. Age	(In yrs. la	st birthday)	If Under 1 Year	ロロ If Under 24		. Date of Bir	th	9. Birth	CO place (State or I	Foreian
	Director		009-40-1235	1 □ M 2 1 5	8	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year) 1951	Verm	try)	or orgin
	d Iow It		Usual Residence of Decedent  10a. State 10b. County		10a City	, Town or Loc	atio			-				
	arykan a-f sh fied a	Director		1100			ation					1	0d. Inside City  1 X Yes 2	
	or 28;	Dire	Maryland Wicom  10e. Street and Number	1100	Sall	isbury	10f. Zip Code	_			10 a Citizon	of What Cour		Z LI NO
	with t	Funeral	105 Times Squa	ire			21801	Ĺ		1	-	JSA	uy r	
	leath items er m	Fun	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.		/as Decedent of H	ispanic Origin	n? (Specify	y Yes or No-		Race - Americ		
36	after o	by	1 Never Married 2 Marrie	1 Yes 2 X	No		Yes, specify Cuba  ☐ Yes 2   ☑ No		Puerto Ric	an, etc.)		Black, White,		
21215-0036	ours attural	Completed	3 Widowed 4 Divorced	Year or Dates.				111111111111111111111111111111111111111				ecify: whi		
5	72 h an "na Medic	mpl	(Specify only highest	grade completed)	,	(Give k	ent's Usual Occup ind of work done o NOT use retired)		of working		16b. Kind	of Business Inc	dustry	
25	within giene. er tha the I		Elementary/Seconday (0-12)	College (1-4 or 5-	+)		worker				man	nufactu	ring	
5	filed all Hyg	Be C	17. Father's Name (First, Middle, La	st)	•			18. Mother	's Name (F	irst, Middle,	Maiden Surr			
yla	uld be Ment narke	မ	Bert Barrett					Ma	rgare	et Bre	nnen			
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. And outcortant if time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Laurien Barrett			19b. Mailing 140	Address (Street a Hathorn	Blvd,	or Rural R Sara	oute Numbe atoga	r, City or Tow Spring	vn, State, Zip (	12866	
ore,	of Heer of Heer fitem rothe		20a. Method of Disposition		20b. Pi	ace of Dispos	ition (Name of atory or other plac	nol .	Dat	e	20c. Locat	ion - City or To	wn, State	
ij	Page ment ant: It		1 ☐ Burial 2 ☐ Cremation 3 4 🗷 Donation 5 ☐ Other (Sp		Anat	comy G:	ifts Regi	stry	3 11	L 10	Hanov	er, MD		
3alt	permit. Depart Import any inj once.		21. Signature of Funeral Service	enree	~	Ho	ALL CANA Addres	uhera	l Hon	ne Pro	fessio	nal As	sociati	on
	40 = W 0		Joseph A	crency (+	300	1 50	JI Snow H	IIII R	a., S	Salisb	ury, M	1D 2180	4	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final	y one dayse on each line.	the death								Approximate Interval Betwee Onset and Dec	
~ P	hysician/ Medical		disease or condition resulting in death)	a hetas	latie		ancrea	tec	Can	-cel	Ĺ		Offset and De	auı
	Examiner			Due to (or as a	conseque	ence or):								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	conseque	ence of).								
	cuted nd transit	Examiner	Cause (Disease or linjury that initiated events	с.										
	e exe	al E	resulting in death) Last	Due to (or as a	conseque	ence of):								
200	icate be executed physician and sthe burial-transit	edical I		d										
89	ding sertific	Ž/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnan	су					224	Date of delive		
Š	eath c	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 4 ☐ Pregnant at			Ectopic pregnand Other (specify)	У			230	. Date of delive Month	ny Day Yea	ar .
O. E.	the d by the ached	Physician/M	9 🗌 Unknown	9 🗌 Unknown										
Division of Vital Records, P.O. Box 687	s that gned oe der	by	Part II. Other significant condition	s contributing to death bu	ıt not resu	Iting in the un	derlying cause giv	en in Part I.					e cause of dear	th?
g.	equire een si ould l	Completed								1 🗆	Yes 2 N	io 3 ☐ Prot	ably 4 🗌 Un	known
00	law re nas be	nple							_	24a. Was autor	osy	prior to coi	sy findings ava	
ag ,	the cate!									perfo	rmed? 2/□ No	death?	₽₽No	
ita	sician certifi rector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:			Oth	ace of Death					66 - 0	
<u>}</u>	Phys r this eral di	은 ::	27. Manner of Death	1 L Inpatie	v [2	R/Outpatient 28b. Time of	3 DOA 28c. Injury	4 🗀 Nurs			ence 6 1		Hospia	2
uc :	nding ath. :: Afte e fune	icate	Natural 5 Pending Accident Investiga	(Month, Day,	Year)	injury	work	? Yes 2 □ N		i. Describe fi	OW HIJUTY DO	curreu		
ISIC	r Affe er dec rector by th	Certificate:	'3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be	ry - At hon	ne, farm, stre	et, factory, office		28f			mber or Rural	Route Number,	176-1-1
<u>S</u>	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afor Attending Physician.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit								4	City or Tow				
:	e Hos 24 ho e Fun eleted	Medical	(Check 2 L Medical Exa	hysician: To the best of naminer: On the basis of extended the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis of the basis o	amination	and/or investig	gation, in my opinic	n, death occι	urred at the	e time, date a	nd place, and	d due to the cau	se(s) and manne	er stated.
:	Nothir Withir Toth	2	29b. Signature and title of certifier		occi or my	Tallo Miloago, at	29c License	number			20d Date sid	anod (Month I	Your Voor	
	1						Do	0571	410		31	10/10		
	100		30. Name and address of person wh	1			int)		4 A				, 0	
	9		31 Date filed (Month Day Year)			Box	1737	7 5	114	rsu	ry	mp -	21802	
	Stat Registra	e	31. Date filed (Month, Day, Year)	010 36 Registrar	s Signat	pa	Red .							

Martha E. Barrett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ELLEN STURCEY CARROLL MARG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** IVISTA CHARI DICAI NITE Social Security Number IF I Ir 8. Date of Birth (Month, Day) Year 9 - 7 - 1 9 4 5 **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F 228-58-6563 64 Director Usual Residence of Decedent 10b. County 10a, State 10c. City. Town or Location If them 27 is marked other than "natural", or items 23a or 28a-f si or other traumatic event, the World Examine and the traumatic event, the World Examine and the traumatic event, the World Examine and the traumatic event, the World Examine and the traumatic event, the World Examine and the traumatic event, the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event and the traumatic event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event e LA PLATA Director MD. CHARLES death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8670 SOUTHERN STAR PLACE 20646 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Never Married 2 Married Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 No Specify. SpecifyWHITE þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) JOBIN REALTY REALTOR marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JULIA PRESBY HAROLD WILLIAM STURCEY မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health a 8670 SOUTHERN STAR PLACE LA PLATA, MD. 20646 JOHN ROBERT CARROLL-SPOUSE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If tte
any injury or ot | Comparison | 2 | Cremation | 3 | Removal from State | Community of State | 3 - 24 - 2010 | WALDORF, MD. M00479 21. Signature of Fyneral Service Licensee RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that aused the death. Do not effer the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** Encephalogath Pati 110 resulting in death) /Medical Due to fr as a consequence of): Examiner Sequentially list conditions, and leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical sate has been signed by the attending page 2 should be detached for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) I∐Yes 2 ZMo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 🗌 Yes Completed

Division of Vital Records, Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

certificate

Be

Certification: To

Medical

2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a, Was an autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2 🗷 No Hospital: 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 27. Manner of eath Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

(Check only one) and manner stated. 29b. Signature and title of certifie

1025

PM

3. Time of Reath

Birthplace (State or Foreign November)

10d. Inside City Limits

1 ☐ Yes 2 XNo

Year

2010

Month

Day

Year

29c. License number 29d. Date signed (Month, Day, Year)

20646, James

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pò BCY P1479 La

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. amend 11cms 7,8 per th g902 4-27-10 vt State of Maryland / Department of Health and Mental Hygiene 09359 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** March 15, Ronald Eugene Clem 2010 10:06 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Maryland Correctional Institution Hagerstown Washington 8. Date of Birth 1954 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 213-64-6255 Yrs. 55 Director Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be nutified at 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10g. Cilizen of What Country? 10e. Street and Number 10f. Zip Code 18601 Roxbury Road 21746 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Wes 2 No 197
If Yes, Give Year or Dates: 197 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1973-1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced 1977 Completed 16a. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Automotive Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked Donald Eugene Clem Marv Louise Jameson 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and item 27 is n Donna M. Clem / Sister 2182 Appalachian Drive Melbourne, Florida 32935 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate permit. Pages Department of N = 5 Important: I any injury o 03/16/2010 | Frederick, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 21. Signature of Funeral Sovice Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. once 7606 Old National Pike Boonsboro, Maryland 21713 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each life. Enter the disease, or complications that or heart failure. List only one cause or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician /Medical resulling in death) **Examiner** asm of Panereatic Head Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest and the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the conditions, in the conditions, if the conditions, if the conditions, if the conditions, if the conditions, if the conditions, if the conditions, if the conditions is the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of t Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) . Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 npatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ☐ Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours a Funeral To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier 24 and manner stated within 2 To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D 44044

Hospitel or Attending Physician:

the

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

31 Date filed (Month, Day Year)

Jonalhan

30. Name and address of person who complete

18601 ROXBURY ROAD

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Julia Ann Churchey 0820 MARCH 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Months Days Nov. 16, Year 1944 217-42-7671 Director 65 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XXes 2 □ No Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 208 East Antietam Street 21782 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo 1 Never Married 2XX Married ģ Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Nurses Aide Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Forrest Irene Draper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dallas Churchey - Husband Sharpsburg, MD 21782 208 East Antietam St. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State WS Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other Specify/ 03-17-2010 Mt. View Cemetery Sharpsburg, Maryland 21. Signature of uneral S 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) week Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami nding physician and use as the burial∗transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical 002 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atte 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 J'CI/E Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA this ( 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Pleotin 24 hours after death.

To the Funeral Director: After it completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number D 44996 29b. Signature and title of cer appans Rd Boonsboro MD 21713 eause of death (Item 23a) (Type, Print) JH-5

DHMH 17 Rev 7/2009

State Registrar

68760

P.O.

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March 12:08pm Jau Deane Cox 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2 Briggs Court Montgomery Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 1 M 2 - F Months Davs Hours 1076871929 Gountry) Missouri 489-30-2206 Director 80 Usual Residence of Decedent or 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number ms 23a or ö 10g. Citizen of What Country? Funeral 2 Briggs Court 20906 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No 1951—
If Yes, Give
Year or Dates. 1953 Black, White, etc ş 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify. White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor FBI ulth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Otis Howard Cox Mary Edith Hawk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Rosemarie Cox - Wife 2 Briggs Court, Silver Spring, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Mem. Park 03/15/2010 | Rockville, Maryland 21. Signature of Funeral Service Licenter 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or shock, or heart failure. List of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Coronary Vascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 1 24b. Were autopsy findings available 24a. Was an autopsy performed?
Yes 2 X No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death To the Hospital or Attending Physicial 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 X Natural 2 No 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) D030247 March 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Morrison, D.O., F.A.C.P., 5410 Connecticut Ave., NW, Washington, DC 20015 State sarked Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Morch 2010 4:30 P M Irene Pocahontas Campbell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Months Days Hours Min 472671921 Washington, DC Director 579-22-1041 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Lanham 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Be Completed by Funeral 5604 Ellerbie Street 20706 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🛛 No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 🛮 Widowed 4 🗆 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland 212 Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George McCloy Gladys Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Congleton/POA 2494 Old Harrisburg Road, Gettysburg, PA 17325 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 3/12/2010 Brentwood, Maryland 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue 22. Name and Address of Facility Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-transii that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day 1 Yes 2 4 detached 9 Unknown I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ANCER 1 Yes 2 No 3 Probably 4 Winknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has autopsy perform 2 1 Yes 2 No 25. Was case referred to medical in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Man or of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be 2 Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completed filled Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

29b. Signature and title of certifier

30. Name and address of person wh

KEVIN

Date filed (Month, Day, Year)
NAR 1 2 2010

8118

pleted cause of death (Item 23a) (Type, Print)

MA

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Luck RZ.

29d. Date signed (Month, Day, Year)

Lanham

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 4 2010 4:11 P **AGATHA** CARRILHO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 1 🗆 M 2 💆 F 579-11-2067 T923 TRINIDAD Director 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sk notified 1 Ty Yes 2 ☐ No PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10g. Citizen of What Country? 'n "natural", or items 23a or edical Examiner must be Completed by Funeral 3201 KIMBERLY ROAD 20782 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc 1 Never Married 2 Married 1 Yes 2 No 1 X Yes 2 No SpecifySPANISH Specify: SPANISH 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12TH CNA PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith and Mental H 27 is marked ot r traumatic ever ည VIRGIL EDMOND OCHOA GLODON FELICITA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 MARY L. DOWDEN/DAUGHTER KIMBERLY ROAD HYATTSVILLE, MARYLAND 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 0 = 1 Burial 2 XCremation 3 Removal from State Department of Important: If any injury or once. 3/16/2010 RIVERDALE CREMATORY ! RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Sen 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a Part 1. En la Illi ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ ANOPIC Medical resulting in death) Due to (or as a consequence of): Examiner ZURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine ARDIAZ anding physician and use as the burial-transit Due to (or as a consequence of resulting in death) Last by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ ¥6 3 ☐ Probably 4 ☐ Unknown Completed CHRONIC OBSTRUCTIVE PULMONARY 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 Yes Other: 2/ No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Il or Attending P safter death. Director: After t work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Baltimore, Maryland 21215-0036

death certificate be execu

Box 68760

P.O.

Division of Vital Records,

State Registrar

WAMIN MD

29b. Signature and title of certifie

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAHID SHAMIM, MD, WASHINGTON ADVENTIST HOSP, TAKOMA PACK

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me,g909,11/19/2010dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Geraldine B. Clutz March 2010 <u>5:3</u>6 p ^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 723 Dover Street Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 💢 F 81 220-20-8115 Sept. 07,1928 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 723 Dover Street USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ∐Yes 2 X No Specify: White Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilmer Snyder Hilda Hess 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Clutz / Son 723 Dover Street Baltimore. MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March Date 2 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD 2010 4 ☐ Donation 5 ☐ Other (Specify) Barrancod & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC CANCER LUNG disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner

be executed

The law requires that the death certificate

Box 68760,

P.O.

Division of Vital Records,

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

Completed by

Be ည MD

**Funeral** 

Director

show

r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Modical Examinari once.

Baltimore, Maryland 21215-0036

death

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Physician/Medical þ Completed Be

Examiner

signed by the a ို After this the funeral Certification: I or Attending Patter death.

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I	IF FEMALE:
ļ	23b. Was decedent pregnant
ı	in the past 12 months?
ı	1 ☐ Yes 2 No

23e. Did tobacco use contribute to the cause of death?

1XYes 2 No 3 Probably 4 Unknown

art II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I.

24a. Was an autopsy 2X No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referre examiner?	d to medical
12 Yes	ю
27. Manner of Death	
1 Natural	5 Pending
2 Accident	investig

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 \sum Nursing Home 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check on
one)

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29h. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVE BALTIMORE MD 21229 AGNES ST E.W. COL 900

State Registrar

filled in by

ca

e Funeral I Hospital

within 2.

6 Could not be determined

32. Reg strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Costas D. Chrissos March 8, 2010 10:52 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day Days 1**X** X M 2 □ F 89 Months Hours 1920 New York 063-12-1869 **Director** Aug. Usual Residence of Decedent 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏝 No Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2586 Golfers Ridge Road 21401 USA 12. Was Decedent Ever in U.S Was Decedent Armed Forces?

1 A Yes 2 No WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or 1 Never Married 2 X Married ≥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: White Completed 3 Uidowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Court Reporter US Senate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Demosthenes Chrissos Kate Ghikas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Louise J. Chrissos / Wife 2586 Golfers Ridge Rd., Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans Cem. 3/16/10 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crownsville, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility George P. Kalas Funeral Home Mulle 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hours Arrythmia Physician/ disease or condition resulting in death) ) Medical Due to (or as a consequence of): **Examiner** Urinary Tract Infection days Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) physician and the burial-transit Anemia death certificate be executed years that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Parkinsons Disease Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🏿 No Yes 2 N 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2XX No ပ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how Injury occurred 28c. Injury at X Natural 5  $\square$  Pending work? I hours after death.

uneral Director: After and filled in by the fun Accident Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Hospital or Attending Physician: To the Hospital within 24 hours a To the Funeral I

> Dely 1201 VA

State Registrar

Jennifer Ruddle Frey 31. Date filed (Month, Day, Year)

(Check

29h

ignature and

30. Name and address of person who completed cause of death (Item 23a) Type, Print) 2007 Tidewater Colony Drive, Annapolis, Maryland 21401

32. Registrar's Signature

3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R135106

29d. Date signed (Month, Day, Year)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 20/0 Minnie R. Culver Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TENINSYLA RESIGNAL Centu SAUSLUCY NICOMIC ial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Days Hours Min. 218-16-5547 Director Delaware 28-1922 Usual Residence of Decedent show 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No DE Sussex Laure1 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12890 County Seat Hwy. 19956 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 X Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail/Antiques Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ည Raymond D. Rogers Blanche Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Robert Wayne Cluver (Son) 12095 Sycamore Rd. Laurel, Delaware 19956 Department of H Important: If iten any injury or otho 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Odd Fellows Cem. 4 ☐ Donation 5 ☐ Other (Specify) 3-10-2010 Laurel, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West ST. Hannigan, Short, Disharoon F.H. Laurel, De. - Hannegor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) VOKE Medical Due to (or as a consequence of): Examiner ZRICARDIAL TAMPONADE Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) Day Year the a 9 Unknown 9 Unknown P.O. I þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has the Hospital or Attending Physician: The law certificate 1 Yes 2 No Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse

Pranticiper: To the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 9 29d. Date signed (Month, Day, Year) 29c. License number 3/8/10 Vol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUSSABER AHMAN 21801 31. Date filed (Month, Day, Year) 32. Regist State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/ 2010 3:08 AM DOUGLAS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Ye March 7, 1 Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Country)
Mary Land Months 218-72-3992 51 **Director** Usual Residence of Decedent or 28a-f show e notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral 8 Monroe Avenue 21701 United States of America within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No 21215-0036 If Yes, Give 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 욘 Paul William Droneburg Doris Gibbons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Droneburg / Wife 8 Monroe Avenue, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State March 26, 2010 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery Frederick, Maryland Signature of Funeral Service. 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): [∉]Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ē Due to for as a consequence of Exami Physician: The law requires that the death certificate be executed burial-transit TOBACCO ABUSE and Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 No signed by the a Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🖾 Yes 2 🗆 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 Yes 2 No 2 😾 No Yes s after death.

I Director: After this certifica of in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Yes 2 TNo 1 ☐ Inpatient 2 √ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death 28c. Injury at -work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending iniury Accident Investigation Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 💢 Certifying Physician: To the performance of the knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the performance of elementary of the ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 — Certifying Nurse Praction, of the syst of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

 $c_{J}$ DIC State

(Check

only one) 29b. Signature and title of certifier

Brian Rader 31. Date filed (Month, Day,

MAR 26

Street

30. Name and address of person who com keted cause of death (Item 23a) (Type, Print)

400

W 7th

32. Revistrar's Signature

of e ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

21701

29d. Date signed (Month, Day, Year)

3/23/2010

to the syst of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c, License number

MDH54869

Frederick, Md.

10-02011 Laylah Dix

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- For State Registrar  State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Reg. No.	36
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time of Death	
	Laylah Elise Dix  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
	Fort Washington Hospital Fort Washington Prince George's	
Funeral Director	5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 M 2 F  7. Age (In yrs. last birthday)  Yrs.  1 Days Hours Min.  2 4 Hours Min.  2 1 1 07/2010  Foreign Country)  ND	r
any	Usual Residence of Decedent  10a. State	v Limits
Varyland 28a-fshow any 1 at once.	b MD Prince Georges Fort Washington 1 ∑ Yes 2	No
th the Maryland 3a or 28a-f sh setified at once		_
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shoor transmatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		k,
nurs aft ttural" amine	6 Ior Dates: Specify Black	
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu c event, the Medical Exa	Elementary/Secondary (0-12)   College (1-4 or 5+)   during most of working life. DO NOT use retired)  Infant   Infant   Infant	
215-003 be filed withintal Hygiene. rked other then, the Med	al Timothu I Div	
2121 ould be fi ould be fi d Mental s marked itic event,	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	-
e, MD	Timothy J. Dix / Father   11801 Maher Dr. Ft. Washington MD 20744	
Baltimore, pernit. Pages 1 at Department of Hee Important: If ite njury or other tr	1 Burial 2 Cremation 3 Removal from State Crematory or other place)	
Baltimore permit. Pages 1 Department of 1 Important: If	4 Departion 5 Other Specify Resurrection Cemetery 03/17/2014 Clinton MD 21. Signs ure of Funeral Service Lines 22. Name and Address of Facility Strickland Funeral Services	
	TESOD Allentown Rd - Camp Springs MD 20748	
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Studdown in form	et and
Examiner	Immediate Cause (Final disease or condition resulting in death)  a Sudden infant death syndrome (SIDS)  Due to (or as a consequence of):	_
P P	Sequentially list conditions,  Diff any, leading to immediate  Due to (or as a consequence of):	
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	
outed nd ransit		
60, ate be execu hysician an e burial - tr	X AMENDED X AMENDED 42, 23a,27, per EM g905 7/30/10 TT	
876( tificate ng phys as the b		ar.
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - transis al Certification: To Be Completed by Physician/Medical Ex	1 Yes 2 No 9 Unknown 9 Unknown	a1
, P.O. res that the signed by be detach	1 Yes 2 No. 3 Probably 4 1 loke	
Records, The law require ficate has been sig, page 2 should be	24a. Was an 24b. Were autopsy findings av autopsy prior to completion of cause	
tal Rection: The later certificate hector, page Be Com		No
/ital	examiner?	
of Vi ing Physi After this uneral dir	77 Manager of Death	
Sion Attend r death. ector: by the f	Natural 5 Pending Investigation 1 Yes 2 No	
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	r, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director. completely filled in by the		
Ž	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  March 12, 2010	
	30. Name and address of person who completed cause of death (Item 23a)	
	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)  32. Registre's Signifure	
State Registrar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Items 25,27,28 - Typer me party ent 9149201686 Mental Hygiene Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 70 2ď10 4:10a M Jr. Linwood Dixon, Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 23372 Hurry Road Avenue 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min. Year) 917 Delaware **Director** 912 10 9805 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits event, the Me rical Examiner must be notified at 10c. City, Town or Location Director Prince George' District Heights Yes 2 🗆 No MD 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral US 2100 Brooks Drive #302 20747 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. ò ò 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 Black 1 Yes X No Specify: "natural" 3 🖵 Widowed 4 🗌 Divorced Completed 44 - 46Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Maintenance and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ be Elizabeth Smith Linwood Dixon, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is 20609 William Mitchell/grandson 23372 Hurry Rd Avenue, MD Baltimore, 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place) MD Nat'l Cemetery 3-18-10 Laurel, MD injury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 21. Sign re of Funeral Service Ligensee any 902 2294 Old Washington Rd Waldorf, MD20601 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final SUBDURAL HEMATOMA Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** CERTIFICATION MEPROVED BY MEDICAL EXAMINER Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown o þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 \sum Yes 2 \sum No 24a. Was an autopsy perform Physician; The Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify GRANDSON 1 မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury
Found, Day, Year)
01/19/2010 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred HOME or Attending injury 5  $\square$  Pending Natural Division 1 🗌 Yes 2 🗶 No Subject fell 2 X Accident UnknownInvestigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 2100 Brooks Drive, #302,District Heights,MD 4 Homicide Home Hospital Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 20 29c, License number 29d. Date signed (Month, Day, Year) H0055751 3-10-10

State Registrar

DHMH 17 Rev 7/2009

40900 Merchants Lane Leonardtown, MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rigistrar's Signature

Jennifer Schmidt, D.O.

MAR 1 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2010 Year Mary Lou Donaldson March 8 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🕱 F Hours 579-42-5102 Director Washington, D.C. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2322 Lakewood Street 20746 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Midowed 4 ☐ Divorced Specify: Completed White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Care Giver and Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Herbert Utley Helen Regina Urbine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie M. Behan/Daughter 1762 Sharwood Pl., Crofton, MD 21114 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Metro Crematory 03/12/2010 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Pa . Enter the di ease, sho k, or heart failure. List r complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Beath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of Examin sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ing physician as the burial Physician/Medical Box 68760 use 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No ρ Month Day Unknown P.O. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes Other: ٩ 1 Nonpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 29a. Certifier 🏿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3. Time of Death

1 Yes 2 X No

12:50

State Registrar 29b. Signature and title of certifier

14.0-31. Date filed (Month, Day, Year)
MAR 12 2010

nd address of person who completed cause of death (Item 23a) (Type, Print)

			For State of			k. Ensure All Copide Health and Mental H	0.01	o. 0 09371
			State Registrar		Certificate of L		Reg. No.	
	Physicia Media		1. Decedent's Name (First, Middle, Last) Enrique Eusebio Diaz			2. Date of D	Death Day Pear OS 201	3. Time of Death 7', 00 PM
	Examir	ner	4a. Facility Name (if not institution, give street and numbe	•		Location of Death	4c. County of De	ath COmic O
	Funeral		5. Social Security Number 6. Sex 7	Age (In yrs. last	birthday) If Under 1 Year	If Under 24 Hrs. 8. Date of E	listh a B	inthologo (State or Femilia)
	Director		070-32-2538 1 X M 2 □ F	79	Yrs. Months Days	Hours Min. 03 05	1931 ct	Country)
	and show lat	jo l	Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location			10d. Inside City Limits
	Maryli 28a-f otifiec	irect	Maryland Wicomico	Sal	isbury			1 ₺ Yes 2 □ No
	ith the 23a or st be n	Funeral Director	10e. Street and Number  1400 Galway Circle		10f. Zip Code <b>2180</b>	Δ	10g. Citizen of What C	Country?
255	eath w	Fune	11. Marital Status 12. Was Deceder	nt Ever in U.S.		spanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.)	1	nerican Indian,
ک\ر 36	after d ", or i camin	출	Armed Force 1 ☐ Never Married 2 🔀 Married  1 ☐ Yes 2 If Yes, Give		If Yes, specify Cuba 1 🌁 Yes 2 □ No		Black, Wh	ite, etc. white
48	ncurs natura ical Ex	etec	3 ☐ Widowed 4 ☐ Divorced Year or Dates  15. Decedent's Education		16a. Decedent's Usual Occupa	ation	16b. Kind of Busines	
ر 215	iin 72 ie. han "r • Med	Completed	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 of		(Give kind of work done of life. DO NOT use retired)	luring most of working		
3212	ed with	Be C	10 – 17. Father's Name (First, Middle, Last)		chef		food ser	vice
Jend .	d e file	0	Eligio E. Diaz			18. Mother's Name (First, Middle Ofelia Prado		
Enright D) Maryland 21215-0036	permit. Page 1 and 2 should re filed within 72 h. urs after death with the Maryland Department of Health and Mr. ntal Hygiene. Department of Health and Mr. ntal Hygiene. Important: If item Z7 is mar ed other than "natural", or items 23a or 28a-f show any injury or other traumati event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)  Jenny D. Stitt/daughter		19b. Mailing Address (Street a	and Number or Rural Route Numb 11 Court, Fruit	per, City or Town, State, 2 Lland, MD 21	Zip Code) -826
Baltimore,	ge 1 and to the street or other		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from Sta	ite cem	e of Disposition (Name of etery, crematory or other place		20c. Location - City of	· ·
altim	nit. Pagartmer ortant injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	Sali	sbury Cremato		Salisbur	_
<u> </u>	Per Pep any any		16ell of Stewer	(FSP	501 Snow	*Ýtheral Home F Hill Rd., Sali	roiessional .sbury, MD 2	ASSOCIATION 21804
	h sician/ Medical Examiner	er.		is a consequence	ce of):	g, such as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
09.	ate be executed by sician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	is a consequent				
). Box 68760	Notice hospital or Autoriang Prysician: The law requires that the death certificate is written to be a start death.  To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the light of the funeral director.	hysician/	1 Yes 2 No 4 Pregnan 9 Unknown 9 Unknown	n 2 🗌 Fetal de t at time of deat n	eath 3  Ectopic pregnanceth 5  Other (specify)		23d. Date of d Month	elivery Day Year
s, P.O.	res that signed by		Part II. Other significant conditions contributing to death	but not resultir	ng in the underlying cause give		tobacco use contribute t Ýes 2 □ No 3 □ I	o the cause of death?
ord	v requi s been should	Completed by				24a. Was	s an 24b. Were a	utopsy findlings available
Rec	ine lav ate has page 2	Som				auto peri	opsy prior to formed death? 2 No 1 7	
tal	clan: certific ector,	Be	25. Was case referred to medical examiner? Hospital:			ce of Death (Check only one)	1	
of V	r this eral dir	e; To	27. Manyner of Death 28a. Date of in	jury 28b	Outpatient 3 DOA Othe	4	idence 6 Other (Spe	cify)
on	anding sath. or: Afte he fund	ficat	1 Natural 5 Pending (Month, L	Day, Year)	injury work?	Yes 2 □ No	now injury occurred	
Division of Vital Records,	or Aug after de Directo in by ti	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of I building,	njury - At home, etc. (Specify)	, farm, street, factory, office		(Street and Number or Ruwn, State)	ural Route Number,
Δ :	4 hours -uneral ted filled	न ज	29a. Certifier (Check 2 Medical Examiner: On the best	examination and	d/or investigation, in my opinior	1. death occurred at the time, date	and place, and due to the	cause(s) and manner stated
4	vithin 2 Fo the Football		only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	ne best of my kno	owledge, death occurred at the 29c. License	time, date and place, and due to t	he cause(s) and manner as 29d. Date signed (Mont	s stated.
	al		AN L. bell	, M	3 0	26278	3-9-1	10
	SU		30. Name and address of person who completed cause of David Couall, MD Caas	death (Item 23a	a) (Type, Print) Pike PO Box 17	33 Salish	MD	21862
	Stat Registra	e	B1. Date filed (Month, Day, Year)  MAR 11 2010  32. Fegis	trar's Signature	park		<i>)</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Mack Eshleman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Allegany Cumberland 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) PA 1 4M 2 - F Month, 18, Year) 928 Hours **Director** 164-22-7398 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified to once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12918 N. Cresap Street 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Divorced Korea white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) pharmacist Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Benjamin Lafavette Eshleman Fern Elizabeth (Traugh) Eshleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 12918 N. Cresap Street Cumberland MD 21502 Mary Eshleman wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Semation 3 Removal from State Scarpelli Funeral Home, P. A. 3/18/201b 4 Donation 5 Other (Specify) Cresaptown MD 21. Signature of Funeral Service 22. Name an Saddreselli Fulleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Desh Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?
1 \( \text{Yes} \) 2 \( \text{No} \) No Pregnant at time of death Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? LEUKEMI 24a. Was an ate has b page 2 s autopsy this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending worl Accident
Suicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical

24 hours within 24 hou

To the Fune

completed fil

> KHANNA 31. Date filed (Month, Day, Year) State 為百台 Registrar

29a. Certifier

(Check

MATIONAL 32. Registrar's Signature

rson who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registraß_16_10Amend#4c.PerPhys.PCCcr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 010 Year March 6, Harvey Kenneth Fitzgerald 9:30 Р Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death County of Death Montgomery re Montogomery Hospice Casey House Rockville Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign March 25, 1 X M 2 □ F Months Days Hours Min. Director 072-20-5335 81 Tenn<u>éssee</u> 1928 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's 1 V Yes 2 No Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7004 Central Avenue United States 20743 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ANo Specify: African 3 Divorced 4 Divorced Year or Dates. American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Photographer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sylvester Fitzgerald Helen Stacy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, Maryland 20904 Shelia D. Moore/ Daughter 11450 Stewart Lane 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Quantico
ational Cemetery 1 X Burial 2 Cremation 3 Removal from State March 2010 16, 4 Donation 5 Other (Specify) Triangle, Virginia Signature of Funeral Ser 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Filysician/ disease or condition Non Hemorrhagic Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year Yes 2 No 9 Unknown 1 ☐ Yes 2 ☐ Unknown r signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ End Stage Renal Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate has been also as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has been as a second of the certificate has a second of the certificate has a second of the certificate has a second of the certificate has a second of the certificate has a second of the certificate has a second of the certificate has a second of the certificate has a second of the certificate has a second of the certificate has a second of the certificate has a second of the certificate has a second of the certificate has a second of the 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 3 🗀 only one) 29d. Date signed (Month. Day, Year) ummen March 9, 2010 less of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Joseph Puthumana,

AR 1 5 2010

MD

6001 Muncaster Mill Rd. Rockville, Md.

20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death Month March Alice Bernice Fitzgerald 2010 1630 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Chever1v 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Months Days 1 🗆 M 2 🔀 F Min. Hours Month, Day, Year, Feb. 28 New York Yrs 78 078-26-0744 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 X Yes 2 No Capitol Heights 10e. Street and Number 10g. Citizen of What Country? 7004 Central Avenue 20743 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: African American 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military Administrator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Gittens Alice Maude Gittens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila D. Moore/ Daughter 11450 Stewart Lane Silver Spring, Md. 20b. Place of Disposition (Name of cemeter, cremator, or other place)
Unantico
National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State March 16, 4 ☐ Donation 5 ☐ Other (Specify) Triangle, Virginia 2010 nature Through Se 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part Enter the disease, or complications that caused shock in heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Cardiac disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physiciani Medical Examiner Examiner

attending physician and for use as the burial-tran

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Certificate:

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10a. State

Examiner

**Funeral** 

**Director** 

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ural", or items 23a or Examiner must be

permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Peripheral

Suicide

4 Homicide

29a. Certifier

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Vascular scase 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? performed?

1 Yes 2 No 1 🗌 Yes 2 🗌 No

25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending iniury Accident Investigation

28d. Describe how injury occurred work?
1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

D0008294

(Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

THEOPHILUS OTWE 3001 Hospital Drive Cheverly, Maryland 32. Registrar

State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2010 March 8, 9:14 а м 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Medical Center Fort Washington Prince George Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊠**M 2□ F Months Days Hours Min 235-54-0934 Oct.5,1935 West Virginia Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 1 □Yes 2 No Charles Maryland Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6802 Dakota Ct. 20616 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 □ No If Yes, Give Year or Dates: Korea Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Washington D.C. College (1-4or 5+) Firefighter Fire Dept. 18. Mother's Name (First, Middle, Maiden Surname) Carl Fields Mildred Woodall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 6802 Dakota Ct., Bryans Road, Md. 20616

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print) Janice Mary Fields 20b. Place of Disposition (Name of cemetery, crematory or other place) March 12, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 21. Signature of Funeral 22. Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640 M00668 23a. Part 1. Enter the sease, or complications that caused the shock, or here to focuse the cause on each line ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw

**Physician** /Medical Examiner

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certificate

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eral Director: After th filled in by the funeral

completely

after death.

physician

**Physician** 

/Medical

Director

Funeral

2

Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

10a. State

Examiner

**Funeral** 

Director

within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Pages 1

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Eventher must be neithed at

Sequentially list conditions, if any, the light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Causé (Firal disease or condi-resulting in death)

Myccard at in Farction	
Due to (or as a consequence of):	
typertension	YEUS
Due to (or as a consequence of):	
Hyperlpidemia	Yeurs
Due to (or as a consequence of):	
Coronay Arten Discipl	Tens

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death

3 Ectopic pregnancy

23d. Date of delivery Month Day

1 ☐ Yes 2 ☐ No

9 Unknown

5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

autopsy performed? 1 ☐ Yes 2 12 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes

Onset and Death

Kefly 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No

Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

2 Accident 3 Suicide

6 ☐ Could not be 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31

29d. Date signed (Month, Day, Year)

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D00404-

29c. License number

104

To the Hospital within 24 hours a To the Funeral E the Hospital

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ON

th, Day, Year) 31. Date filed (Month) State Registrar

29b. Signature and title of certifie

32. Registrar's Signature

Barke

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 2010 0830 March 16 Arietta Elizabeth Glassman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ceci1 E1kton Union Hospital 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 26, 1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F Director 232-50-3564 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Expandent must be it officed. 1 ☐ Yes 2 X No Director E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21921 United States 20 Montrose Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) alth and Mental Hygiene.

27 is marked other than* Elementary/Secondary (0-12) College (1-4or 5+) Meat Wrapper Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Kelly Whitaker Renie Virginia Hankins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Reba J. Brandon/Daughter 107 Bradley Run Road, Elkton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul S 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 March 19 St. Paul's Lutheran Cemetery 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2010 Aberdeen. MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Hicks Home for Funerals, 103 W. Stockton Street, Elkton, 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death unknown **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Medities 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Pruneral Director: 6 ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated within 24 29c License number **3** 8 8 **23322** 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and tip of certifier

31. Date filed (Month, Day, Year)

Jackder Smo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. SHCHDEV MD 126 A E HUN

126 A E thigh

3.16.2010.

Elkan MD 21921.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 7010 1905 PM Charles Bernard GOCHENOUR, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day Year) Sept. 17 1964 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Months Mary land Director Sept. 219-86-5143 45 Usual Residence of Decedent show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 X No Smithsburg Maryland| Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14450 Stottlemyer Road 21783 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 HVAC Technician Commercial Systems permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles B. Gochenour, Sr. Peggy Rothgeb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Gochenour - Daughter 20306 Youngston Ct. Apt. 2807, Hagerstown, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 3/17/10 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, MD. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition weet # Medical resulting in death) Due to (or as a consequence of Examiner LLO NENHRITIS Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on requires that the death certificate be executed nding physician and use as the burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINE that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ SMALL BOWEL OBSTRUCTION Division of Vital Records, 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown Completed STAPH ARELS PNEUMOWIA 24a. Was an ADVLAPLEGIA 24b. Were autopsy findings available prior to completion of cause of ESV2D - MAINTENANCE DIALYSISLUSS STOPPEN performed? death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှု Inpatient 2 ER/Outpatient 3 DOA After this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of I or Attending P after death. Director: After t Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending М Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

54-0

DHMH 17 Rev 7/2009

140THOMAS JUHNSON DR

SUHNSUN, MY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Year 2910 **Physician** 8:00AMM Patrick Christopher Giles 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 829 Rosehill Ave. Washington County Hagerstown 8. Date of Birth (Month, Pay, Year) July 17,1961 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1XM 2□ F Months Days Hours Min. 042-54-4875 48 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Washington County Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 829 Rosehill Ave. 21740 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, If a Mexical Example and unust 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Home Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hence Giles Marie Sandbower Giles ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy E. Giles-wife 829 Rosehill Ave. Hagerstown, MD 21740 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 3-12-2010 Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LECTROLTTE ABADRANCITIE Physician /Medical Due to (or as a consequence of): **Examiner** Espo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by HYOBSTRENI 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 □ Yes 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 20002313 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3-12-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eli Roza 12931 Oak Hill Ave. Hagerstown MD 21742 5H-2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 17 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2010 **Physician** March 4:40 A M Jacob William Gilmer, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County 18526 Indian Cottage Rd. Hagerstown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1X M 2□ F Months Hours 173-20-5464 1925 Pennsylvania 6, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland Washington County Hagerstown 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 21742 U.S.A. 18526 Indian Cottage Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 1943If Yes, Give 1943Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1∐Yes 2∭XNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced Be Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Mfg. Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sallie Rush Gilmer Jacob William Gilmer, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 107 Bowsprit Lane North Grandy, NC 27939 Denise Menard-daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 3-16-2010 Hagerstown, Maryland Rest Haven Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cass Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 5 Residence 6 □ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide

Box 68760. P.0. Division of Vital Records,

The law requires that the death certificate be executed physician and the burial-transit attending pl by the a s been signed b has been see 2 should this certificate or Attending Physician: director, After thi within 24 hours after death

To the Funeral Director:
completely filled in by the f Hospital

**Funeral** 

Director

e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

d other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, once.

**Physician** 

/Medical

Examiner

24 9+1

State

29a. Certifier

edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner; On the basis of examination and and manner stated.		
Ř	29b. Signature and title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 2)a) (T	ype, Print, Mr. Ale / Kg	erston MDZ1742
e ar	32. Registrar's Signature	dans	/

(Earlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

**Please** 

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene							
State of Maryland / Department of Health and Mental Hygiene 40 10 0							
Certificate of Death	Reg. No.						
	O Date of Dooth	0. Time of Booth					

		4	State Registrar		Ce	rtificate of L	Death		Reg. No.	
1. Decedent's Name (First,				Last)				2. Date of Dea		3. Time of Death
	Physicia Medic	al	BESSIE				MARCH	9 2010	6:00 A M	
	Examin	er	4a. Facility Name (if not institution,	give street and number)			Location of Death		4c. County of Deatl	
			106 ESSENTON DR		last blothdad	UPPER If Under 1 Year	MARLBORO  If Under 24 Hrs.	Lo Data of Dis	PRINCE GI	
	Funeral Director         577-52-5766         1 □ M 2 ☒ F         81         Yrs.         Months Days Hours Min. (Month, Day, Year) MAY 7 1928					y, Year) Cou	hplace (State or Foreign intry) TNTA			
	and show d at	ايا	Usual Residence of Decedent  10a, State 10b, County	10	c. City, Town or Lo	ocation	-			10d. Inside City Limits
	Marylan 28a -f st otified a	irecto	MD PRINCE	GEORGE'S	UPPER M	ARLBORO				1 X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number 106 ESSENTON DR	IVE		10f. Zip Code 20774			10g. Citizen of What Co USA	untry?
2036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f sho item 27 is marked other than "natural", are items 25a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 ☐ Never Married 2 ☒ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Puerto Specify:		14. Race - Amer Black, White Specify:	
21215-0036	vithin 72 hou iene. r than "nat the Medica	Completed by	15. Deceden (Specify only highes Elementary/Seconday (0-12) 1 2 T H		(Give	edent's Usual Occup kind of work done of DO NOT use retired) SEWIFE		ing	16b. Kind of Business PRIVATE	ndustry
Maryland 2	ild be filed w Mental Hyg narked othe atic event,	To Be	17. Father's Name (First, Middle, La TURNER FERGUSO)	•				ne (First, Middle, WILLIAM	Maiden Sumame) 1S	
	and 2 should Health and Mi tem 27 is mar ther traumati		19a. Informant's Name/Relationsh						er, City or Town, State, Zip RLBORO <b>,</b> MARYL	
Baltimore,			20a. Method of Disposition 1   Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	2 Removal from State		osition (Name of ematory or other place IS COMM.		Date 9/2010	20c. Location - City or HUME, VIRGI	
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	censee		22. Name and Addre			CINS FUNERAL	
- 1	hysician/	( )	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that caused the ally one cause on each line.  ALZHEIMER			g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a co	consequence of):					
0	rificate be executed ing physician and s as the burial-transit	Medical Exa	that initiated events resulting in death) Last	Oue to (or as a co	onsequence of);					
8760	icate g phy is the	ledi								
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1  Live Birth 2 4  Pregnant at tir 9  Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of de Month	ivery Day Year
s, P.O.	ires that th signed by d be detac	þ	Part II. Other significant conditio	ns contributing to death but r	not resulting in the	underlying cause gi	ven in Part I.		tobacco use contribute to	
Division of Vital Records,	The law requirate has been page 2 shoul	Completed							ppsy prior to death?	topsy findings available completion of cause of
ᆵ	an: Tl tiffical tor, p	BeC	25. Was case referred to medical	1		26. P	lace of Death (Chec		22110	
ΖË	ysici is cer direc	일	examiner? 1  Yes 2  No	Hospital: 1  Inpatient	2 ER/Outpati	ent 3 DOA Oth	er: 4  Nursing H	ome 5 🙀 Resi	dence 6 Other (Spec	ify)
n of	nding Ph ith. : After th e funeral		27. Manner of Death  1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident Investic		28b. Time injury	wor		28d. Describe I	how injury occurred	
Divisio	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate:	3 Suicide 6 Could a 4 Homicide determ	not be 290 Place of Injuny		treet, factory, office		28f. Location ( City or Tou	Street and Number or Ru wn, State)	ral Route Number,
_	n 24 hour ne Funera le Funera	Medical	(Check 2 Medical E	Physician: To the best of my xaminer: On the basis of exam Nurse Practioner: To the bes	nination and/or inve	estigation, in my opini	on, death occurred:	at the time, date a	and place, and due to the	cause(s) and manner stated.
	To the To the Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex Complex		29b. Signature and title of certifier	1		29c. Licens	e number		29d. Date signed (Monti	
			1/h	un			0343		MARCH 10	, 2010
R	5		30. Name and address of person with the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa	who completed cause of deat D. 14999 HEAL			201 BOW	IE, MARY	LAND 20716	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 2 2010	Access 32. Registra's	Signature	,				

DHMH 17 Rev 7/2009

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			State of Marylar	nd / Depa		of He	alth a	_			
	<b>.</b>	,	1. Decedent's Name (First, Middle, Last)					2. Date of D	Death	trues of 5	3. Time of Death
	Physicia Medi		Stanley Greenberg		March 1					^y 20°f'(	5:18p м
~ ~	Examir	er	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death							County of Dea	
	·		4735 Queens Grove Street White Plains  5. Social Security Number   6. Sex   17. Age (In vrs. last birthday)   If Under 1 Year   If Under 24 Hrs. 1 8. Date of								
	Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1 🖾 M 2 🗆 F  7. Age (In yrs. last birthday)  Yrs.  1 🖾 M 2 🗀 F  7. Age (In yrs. last birthday)  Yrs.  1 Var   If Under 24 Hrs.   8. Date of E						0	rthplace (State or Foreign	
	T M		Usual Residence of Decedent								
	ryland -f sho ied at	당		ty, Town or Loc							10d. Inside City Limits
	ne Ma nr 28a notif	Pie.	MD Charles Wh	ite P	10f. Zip Co				100 0	tizen of What C	1 Yes 2 No
	with the 23a c	la l	4735 Queens Grove Street		206				-	U.S.A	ound y?
	eath y	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.	S. 13. \	Nas Deceden	t of Hispa	nic Origin	n? (Specify Yes or No Puerto Rican, etc.)	0-	14. Race - Ame	
36	ifter d ", or i		1 ☐ Never Married 2 【XMarried Armed Forces? 1 丛 Yes 2 ☐ No If Yes, Give		res, specily 1 ☐ Yes 2 [			Puerto Rican, etc.)		Black, White Specify: Wh	
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates.		dent's Usual C						
15	an "na Medi	ldm	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	(Give I	kind of work a O NOT use re	done durir	ng most o	of working	16b. K	ind of Business	Industry
212	within /giene.		College (1-4 or 5+)	Entr	epren	eur			Pr	ivate	
pu	be filed ental Hy 'ked oth ic event	To Be	17. Father's Name (First, Middle, Last)			1		s Name (First, Middl		S <i>urname</i> )	
yla	uld be fill d Mental narked o	-	Charles A. Greenberg					e Benof:			
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merital Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)  Patricia Greenberg/Wife					or Rural Route Numi e St. Wh			p Code) , MD. 20695
	1 and 2 st Health item 27 other tr		20a. Method of Disposition 20b. F	Place of Dispo	sition (Name	of	- :	Date	200 1	ocation - City o	Town State
D E	o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Kii	ng bay Gard	Pia Me	mör	ial	3/18/10	Fal	ls Chu	rch,MD
Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee M15	95	. Name and A	Address o	f Facility	Briscoe-	-Toni	ic Fun	eral Home f,MD.20601
	_		23a. Part 1. Enter the disease, or complications that caused the deat							valuor	Approximate
with the	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	120	e H	P (	ent	- Fa	ile	up	Interval Between Onset and Death
أريد	Medical Examiner		resulting in death)  a. Due to (or as a consequence)								
Н	Examiner	7.	Sequentially list conditions, b.								
	sit sit	mine	if any, leading to immediate Due to (or as a consequences. Enter Underlying Cause (Disease or iinjury	uence of):							
	be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence)	uence of):							
0		ical	l d								
376	ificate ig phy as the	Med	IF FEMALE.								
Box 6876	e death certificate b the attending physi hed for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnat 1 ☐ Live Birth 2 ☐ Feta	al death 3	Ectopic pred Other (speci					23d. Date of de Month	elivery Day Year
P.O.	Attending Physician: The law requires that the dearn or death. ector: After this certificate has been signed by the aby the funeral director, page 2 should be detached by the funeral director, page 2.		Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cau	ıse given	in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
S,	v requires that s been signed t should be deta	Completed by						1 [	Yes 2	□ No 3 □ F	robably 4 Unknown
orc	w req	plet						24a. Wa		24b. Were au	topsy findings available completion of cause of
Rec	s <b>ician:</b> The law i certificate has k lirector, page 2 s	Com							opsy formed? s 2	death?	s 2 No
ta	cian: ertifica ector,	Be	25. Was case referred to medical examiner?		2		of Death	(Check only one)			
Ξ	ohysic this c	2:	1 Ves 2 No Hospital: 1 Inpatient 2 2  27. Manner of Death 28a. Date of injury				4 🗌 Nurs	ing Home 5 Re			cify)
0 U	ding I h. After funer	cate	1 Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of injury	M 28c.	Injury at work?	2 🗆 N	28d. Describe	how injury	y occurred	
Sio	I or Atteno after deat Director: I in by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	ome, farm, stre			- 2 - 1		(Street and	d Number or Ru	ıral Route Number,
Division of Vital Records,	al or safte		building, etc. (Specify	)					own, State)		,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Oertifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the best of my	n and/or invest	igation, in my	opinion, c	leath occu	irred at the time, date	and place	, and due to the	cause(s) and manner stated
	To the within 2 To the comple		29b. Signature and title of certifier		29c. Li	icense nu	mber		29d. Dat	te signed (Mont	h, Day, Year)
	BBSV		30. Name and address of person who completed cause of death (Item	1 23a) (Type, P	Print)	4		Mn	1	064	<u></u>
	Sta	е	31. Date filed (Month, Day, Year) 32. Registrar's Signar	ture	, (	0			U	- 0 1	V
	Registra		MAR 15 2010 Lemma &	. four	Kel						
DH	MH 17 Rev 7/20	009	,								

09382

5:44 p^M

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

VA

Black

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Cecelia Denise Graham March 10, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) 1 □ M 2 □ F Yrs. 227-98-7180 Director 50 01/04/1960 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Examinations to prodiffed at Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3643 Elder Oaks Blvd #6209 Funeral 20716 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 N Yes 2 No If Yes, Give Year or Dates: 1986 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐Yes 2 ☐No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Private permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Barbara Ann Graham ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauren Moore/Daughter B643 Elder Oaks Blvd. #6209 Bowie, MD. 20716 20b. Place of Disposition (Name of cemelery, crematory or other place)
Maryland Veterans
Cemetery
3/30/10 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home M1595 2294 Old Washington Rd. Waldorf, MD. 20601 edric 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

shock, or heart failure. List only	one cause on each line.			Interval Between Onset and Death
Immediate Cause (Final disease or condition	a. Intracerebral	Bleeding		Days
resulting in death)	Due to (or as a consequence of):			-
Sequentially list conditions, if any, leading to immediate cause. E. for Underlying Cause (Disease or injury	b			
Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of):			
l	▶d			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)	230	d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the un	derlyin <b>g</b> cause given in Part I.		contribute to the cause of death?
			24a. Was an autopsy performed? 1 □ Yes 2 ØNo	24b. Were autopsy findings availab prior to completion of cause o death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
1 Yes 2 ANO	Hospital: 1 😾 Inpatient 2 🗆 ER/Outpatient	3 □ DOA Other: 4 □ Nursing H	ome 5 Residence 6	Other (Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury o	ccurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street and N City or Town, State)	Number or Rural Route Number,
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause(s) ar rred at the time, date and pl	nd manner as stated. ace, and due to the cause(s)
29b. Signature and title of certifier	1	29c. License number	29d. Date s	signed (Month, Day, Year)
	- C. V	DM35494	03/1	1/2010

State Registrar

Parkway Annapolis, MD. 21401

2001 Medical

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Steven Resnick,

MAR 152010

31. Date filed (Month, Day, Year)

			Pleas	se Type or Pri			<mark>delible lnk</mark> artment of H			•		•				
			For State Registrar	Otate of W	arylaria	•	rtificate of				Reg. No	2010	0938	3:		
ı	Division		1. Decedent's Name (First, Middle,	Last)	·				2.	Date of Dea Month	th Da	v Year	3. Time of Death	1		
	Physicia /Medic		John Calvin					Ma	rch	11	, 2010	5:56A	М			
	Examin	er	4a. Facility Name (If not institution, 8605 Bel Alton	-			4b. City, Town, o		of Death		4c.	Charle				
	Euroval				au ge <i>(In yr</i> s. <i>I</i> as:	t birthday)	Bel A		er 24 Hrs. 8.	Date of Birth	h	Charle:	place (State or Fore	eian		
	Funeral Director		218-38-9295	1 M 2 □ F	67	Yrs.	Months Days	Hours	Min	(Month, Day	/ Year)	Cor	intry) nington D(	-		
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Four or La	eation						10d. Inside City Lim			
	laryla shov	ō		arles	,							1 □Yes 2 🛣				
	the N 28a-	Director	MD Ch.	В	el Al	10f. Zip Code				10a. Cit	izen of What Cou	intry?				
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, I're Medical Examiner must be notified at	al Di	8605 Bel Alton	20	611			_	USA							
	ems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces? 1 X Yes 2 □	Ever in U.S.	13.	Was Decedent of H	Hispanic O	origin? (Specifian, Puerto Ric	y Yes or No- an, etc.)		14. Race - Amer Black, White				
36	s after	by Fu	1 Never Married 2 Marrie	No	1	1 □ Yes 2 X No			,,			White				
1215-0036	hours tural	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:		16a Dece	dent's Usual Occup	nation	-		16h K	ind of Business/li	ndustry	_		
Ċ	in 72 n "na Nodio	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or		(Give	kind of work done DO NOT use retire	durina mo	est of working	î	100.10	ind of Dusiness/ii	loustry			
	d with giene er tha	Com	12	College (1-407)	o+)	Mas	ster Plum	ber			F	lumbing	ng			
g	be filed tal Hygi d other event, I	Be (	17. Father's Name (First, Middle, L	*				!	her's Name (F			•				
<u>X</u> a	Men Men arke	욘	Thomas Francis						Ldred C							
Baltimore, Maryland 2	tra tra		19a. Informant's Name/Relationshi				ng Address (Street					_	ip Code)			
<u>စ</u> ်	ss 1 and of Health item 27 r other tr		Lema Jean Golds 20a. Method of Disposition	smith/Wife	20b, Plac	e of Disoc	Box 126	-	L Alton Date		206. Lo	L ocation - City or T	own, State			
<u></u>	w - <del>-</del> -	. 9	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp				matory or other place lemorial		3/15/2	.010	Wal	.dorf,Mai	rvland			
<u>=</u>	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service L	Access of	M01458		AREHART-	1					<i>y</i> ======			
ñ		6 1	Ganil T. Li,	dell in	101430	69							546			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,													
	Physician	9 4	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  Due to (or as a consequence of):													
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):	0	- 4	47	0-0	_					
		Ē	Sequentially list conditions, if any leading to immediate by									-6				
	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying  Cause (Disease or injury that initiated events													
'n	executed an and rial-transit															
2/60	eath certificate be executed attending physician and for use as the burial-transit	edical		d												
/80 X	certificate nding physise as the I	Med	IF FEMALE:													
X R R	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal de	eath 3	Ectopic pregnanc	су				23d. Date of deli Month	very Day Year			
o.	that the death led by the atter detached for u	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a	at time of dea	tn 5L	Other (specify) _									
7.	w requires that the de been signed by the should be detached		Part II. Other significant condition	ns contributing to death t	out not resulting	ng in the u	nderlying cause giv	ven in Part	t I.	23e. Did to	bacco	co use contribute to the cause of death?				
Records,	requires seen sign hould be	ed by	1 Tes								es 2	□ No 3 12 Pro	bably 4 🗌 Unknow	wn		
ပ္က	law rec as bee 2 shor	Completed								24a. Was a		24b. Were aut	opsy findings availal	ble		
ř	The law ate has bage 2 s	mo	25. Was case referred to medical examiner?  1 Yes 2 No								med?	death?	ompletion of cause of 2 □ No	זנ		
VItal	cian: ertific ector,	Be										10 103 2010				
5	Physic this c	ပ္											rify)			
	ding I	ion									ry occurred					
DIVISION	deatl deatl ctor: y the	fical	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street):							Street ar	t and Number or Rural Route Number,					
	al or / s after Il Dire	Certification:	4 Homicide determined determined building, etc. (Specify)													
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)	Physician: To the best examiner: On the basis and manner si	of examination	edge, deat n and/or ir	h occurred at the ti	ime, date a opinion, de	and place, and eath occurred	d due to the d at the time, d	cause(s	s) and manner as d place, and due	stated. to the cause(s)			
	To th To th comp	Me	29b. Signature and title of certifier	10			29c. Licens	se number	-	2	29d. Da	te signed (Month	, Day, Year)			
			* FMa	the			D28	-35	2		3 -	-12-1	0			
1	3B 10N	WA	30. Name and address of person w	/ho completed cause of	death (Item 23	3a) (Type,	Print) PK1	risha	n Math	ur M.D	) (	646				
	Sta		31. Date filed (Month, Day, Year)	32 degist	ar's Signatur	1	ules	-								
	Registra		WAR 12	2010 Leneu	NA	1916	House									
υHl	MH 17 Rev 1/20	JU1														

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9332PM March Eva Gepert 6 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea 11/5/1926 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 M 2 D F 83 165-20-2037 Pennsýlvania Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the "Madical Examinar in ust be refilled at 1 ☐ Yes 2 No Director Maryland Prince George's Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 USA 9507 Sheridan Street by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21′215-0036 If Yes, Give Year or Dates 1 □Yes 2 🛣 No Specify Specify: 3 ☐Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Milczakowski Catherine Lesknicz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1528 McKinan Court Severn, MD 21144 Raymond L. Gepert/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3/10/2010 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home - P. Free 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arova /Medical Due to (or as a consequence of): Examiner Due to (or paconsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Due to (or as a consequence of): burial-1 physician Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t page 2 s autopsy certificate 1 □Yes 2 □ No 1 □Yes 2 🗖 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation

Box 68760. P.O.

Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

10

State Registrar

Delbert Morales 31. Date filed (Month, Day, Year) MAR 1 0 2010

30. Name and address of person who completed

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

4 🗌 Homicide

(Check only one)

29b. Signature and title of celtific

MD. 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

vause of death (Item 23a) (Type, Print)

Centerway

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my relation of the cause of examination and or investigation in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Greenbelt, MD.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1 tem 11 per FH G901 3/26/10 dk.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March JOHN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimone washington Medical Centu Glen Burnie Anne Arunde Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Date of birth (Month, Day, Year 216.34.1866 1 □ M 2 🗹 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No *MASADENA* 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital_Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. arried 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) //Seconday (0-12) HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCHANT Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-22-10 POENTON 21. Signa 22. Name and Address of Facility AughERTY TWERS! HOME 100942 2601 MOUNTAIN PASADENA Part 1. Enter the disease, or complications that soused shock, or heart failure. List only one cause on each line aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Myocan Onset and Death +nysician/ disease or condition Medical resulting in death) Due to ras a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine SWemzi sician and burial-trans Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Vear Pregnant at time of death sate has been signed by the page 2 should be detached P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, To the Hospital or Attending Physician: The law requires 2 🗌 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 ☐ 💢 o 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Anpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After to completed filled in by the funera 1 Natural 2 Accident 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier з 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 201 Med? Cal . M1

DHMH 17 Rev 7/2009

State Registrar egistrar's Signature

			for State of Maryland / De State of Maryland / De C	partment of F ertificate of		reg.							
	Physici	an	Decedent's Name (First, Middle, Last)				Day Year	3. Time of Death					
	/Medic	al	DORIS MARIE HEDDEN  4a. Facility Name (If not institution, give street and number)	4b. City. Town, c	or Location of Death		18-2010 9:55 4c. County of Death						
	Examir	er	5328 LILY COURT		LATA		CHARLES						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Monthe Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 5 – 22 – 1	9. Birthr 934 TEN	place (State or Foreign otry)					
	Director		535-32-7642			3-22-1	754 1511						
	aryland show	_	10a. State 10b. County 10c. City, Town or MD • CHARLES	LA PLAT	17\		1	0d. Inside City Limits 1 ☐ Yes 2 No					
	28a-f	ecto	10e. Street and Number	10f. Zip Code	<u> </u>	100	. Citizen of What Country?						
	3a or	I Di	5328 LILY COURT	46	U.S.A.								
	r death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	3. Was Decedent of H	Hispanic Origin? (Sp van, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.						
36	72 hours after death with the Maryland hatural", or items 23a or 28a-f show digal Examinor must be notified at	<b>by</b> Fi	1  Never Married 2  Married 1  Yes 2  Yo If Yes, Give 1  Year or Dates:	1 □Yes 2 □ No			Specify:WHI'	TE					
2-0	72 hou	ted	15 Decedent's Education 16a. De	cedent's Usual Occup	pation	ing 16b	. Kind of Business/In	dustry					
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/lan	2 should be filed within 73 n and Mental Hygiene. ' is marked other than "n raumatic event, the Medi	To Be	FRANK GOODMAN		PAULINE	E FAW							
Maryland 21215-0036	2 sho n and l	ľ					ity or Town, State, Zip						
	1 and Health tem 27		20a Method of Disposition 20b. Place of Dis	8 LILY C	1		MD. 2064 Location - City or To						
m _o	Pages nent of int: if if		1∑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	rematory or other pla ATIUS CE	M. 3-26	5-2010 C	HAPEL PO	INT, MD.					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be profitted at once.		21. Signature of Funeral Service Licensee M0 0 4 7 9	22. Name and Addre	ess of Facility	SERVICE	.P.A.						
	Physician /Medical Examiner		23a Part 1 Enter the disease or complicationed in training the death. Do not	RAYMOND LA PLATA	MD. 206	or respiratory arrest		Approximate					
80			23a. Part 1. Enter the disease, or complications in t caused the death. Do of shock, or heart failure. List only one cuts in each line.	Pon	10041	CIVEAR C	EMC12/4)	Interval Between Onset and Death					
			disease or condition resulting in death)  a. The first of the consequence of:										
		ř	Sequentially list conditions, if any leading to immediate  b. Due to (or as a consequence of):	NACT	ALCUV	eve_		wow by					
	cuted nd ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decorpting Cause of Killer) that initiated events	FIRST	RILBT	DOW		year.					
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Box (		n/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnano	CV		23d. Date of deliv	*					
O. B	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/M		5 Other (specify)			Month	Day Year					
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a B	r: The					performed 1 □ Yes 2	death? No 1 □Yes	2 □ No					
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Division of Vital Records,	ng Phy fter thi neral o	on:To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) Injur	e of 28c. Inju	ıry at	28d. Describe how		-37					
Sio	ttendil death. tor: A the fu	icatic	2 Accident investigation	at and Number or Dur	nl Pouto Number								
Divi	after of Direct of in by	Certification:	3 Suicide 3 Suicide 4 Homicide 4										
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/o	eath occurred at the t	time, date and place	, and due to the cau	se(s) and manner as	stated. to the cause(s)					
	the H thin 24 the F	Medical	one) and manner stated.  29b. Signature and title of certifier	29c, Licens			. Date signed (Month,						
	<b>5.85</b> 8		Jun / Low	D	2062	9	3/19/	10					
			His weap addr. s of person who completed cause of death (Item 23a) ( )	Frint)	011.			0 01 (97					
			31. Date filed (Month, Day, Year)  32. Degistrar's Signature	12/0/11,	UWA	Cholor	· VVIC	20005					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>10</u> Physician/ March 6 Amanda Hall 1:10 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Health & Rehab. Center Ft. Washington Prince George's 8. Date of Birth
(Month, Day, Yea 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 ☐ M 2 🛣 F Months Days Hours 578-84-5350 Maryland Director 49 1960 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No Prince George's Oxon Hill Maryland ō 10e Street and Number 10f Zin Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be Funeral 5638 Livingston Terrace Apt.# 201 20745 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. African Armed Forces? ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 N Divorced American the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Office Manager/Assistant Private permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Jackson Carlene Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 201 Silver Spring, Md Melodie Venee Shuler/ Daughter 817 Silver Spring Ave. Apt. 20c. Location - City or Town, State Wash. DO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4/1/2010 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, MD 22. Name and Address of Facility Stewart Funeral Home. . Sionature of Funeral Sei 20019 Benning Rd. NE Washington, 23a. Part | Enter the disease, shock, or heart failure. List mplications that, caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due Examiner Securitions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 Dunknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 2 🗆 No 1 Tes 25. Was case referred to medica 26. Place of Der th (Check only one) Be examiner? 2 🗹 No Other: 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 TResidence 6 Other (Specify) မ 1 🗌 Inpatient 2 🗍 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 Tes 2 🗆 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month. Day, Year)

State Registrar 7700 Old Branch Ave. Suite C-101 Clinton, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxmi N. Berwa, M.D.,

F.A.C.P.

32. Registrar's Signature

20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 March 8. John Hendren Holmes 15:40 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Hours March20 1930 215-26-7388 79 Mary Pand Director Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Sonata Way 20901 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married þ Baltimore, Maryland 21215-0036 White 3 Divorced 4 Divorced Specify: "natural" Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) District of Columbia Environmental Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Brundick George Evans Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Sonata Way Silver Spring, Maryland 20901 Margaret H. Gordon -friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 3/15/2010| 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licens Transfer Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physiciani Recurrent Squamous Cell Cancer of left face disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to minisurate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, Exami Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ğ Pregnant at time of death Month Day Year signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 XNo this certificate 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 🗌 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours a er dezth.
Funeral Director: After eted filled by the funer (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. only one) 29b. Signature and title o 29c, License number 29d. Date signed (Month, Day, Year) March 8, 2010 D66249 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Duran, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 5 Day 2010 Year William Baker Hagan 7:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
December 26,1918 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days 1 ፟፟፟፟ M 2 □ F Hours 213-18-5974 91 Salisbury, MD Director Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director Prince George's Hyattsville 1 X Yes 2 ☐ No Marvland 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? **23**a Funeral 3921 Commander Drive 20782 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give T.T. 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Year or Dates. WWII other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) General Surgery Medical Doctor Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Hagan Louella Ouillen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Quillen Hagan / Daughter 3921 Commander Drive, Hyattsville, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 3/9/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Eurheral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. l'art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequent of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 N certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending iniury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Contifying Name Fractioner: To the basis of my knowledge of all occurred at the time, date and place, and the cause(s) and manner as used. (Check 29b. Signature and title of certifig

(157) State

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

MAR 1 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Suresh Gupta 3001 Hospital Dr. Cheverly, MD 20785

3.6.2010

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÷		-	Registrar  1. Decedent's Name (First, Middle,		tineate or i	Dear		. Date of De	Reg. No. 3. Time of I								
	Physicia /Medic		Lucille Cathe				Month arch	2010	Year	2:10							
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or				4	lc. County					
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	Funeral Director		5. Social Security Number 578–20–6516	st birthday) Yrs.	If Under 1 Year Months Days	Hour	der 24 Hrs. 8 s Min.	Date of Bi (Month, Di ec. 2	920	9. Birthplace (State or Foreign Country) Virginia							
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation						1	0d. Inside City	Limite		
	laryla shov	'n	,										1 ☐ Yes 2 ▼No				
	the N 28a-f notifie	rect	Maryland Montgomery Takoma Park  10e. Street and Number 10f. Zip Code 10g. Citizen of What									/hat Cour	itry?				
	with 3a or t be	Funeral Director	7525 Carroll Av	Anna			20912					S.A.		•			
	ms 2; mus	nera	11. Marital Status	12. Was Decedent B	ver in U.S.	13.	Was Decedent of H	ispanic	Origin? (Speci	fy Yes or N		14. Race		an Indian,			
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fui	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?  ed 1 □ Yes 2 ★ N  If Yes, Give  Year or Dates:	lo	1 ☐ Yes 2 💢 No	can, etc.)			k, White, Whit							
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	Page nent c		1 $\upbeta$ Burial 2 $\square$ Cremation 4 $\square$ Donation 5 $\square$ Other ( $S_{\mu}$		Trin	nity N	lem. Gard	ens	3/11/	2010	Wa	aldor:	E, MI	)			
פפ	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service ticensee M00668 Williams Funeral Home, P.A.														
	SERVICE STATE		23a. Fart1. Enter the discusse on each line.  23a. Fart1. Enter the discusse on each line.  2470 Hawthorne Rd., Indian Head, Md. 20640  Approximate shock, or he in line. List only one cause on each line.														
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	Physician /Medical		Immediate Cause (Final diseases or condition resulting in death)  Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):										-				
	Examiner																
	T ==	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to or as	a conseque	nce of):											
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O. DOX	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown											ear			
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2   2	or Attending Physician: The law for death. Wirector; After this certificate has in by the funeral director, page 2.	Certification:	3 Suicide 4 Homicide  3 Suicide 4 Homicide  4 Homicide  4 Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number or Street)  City or Town, State)									er,					
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	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	(Check only 2 Medical I	Examiner: On the basis of and manner sta	examination		vestigation, in my	opinion,	death occurred		e, date a	and place,	and due t	o the cause(s)			
	To 1	Σ	29b. Signature and title of certifier	1			29c. Licens					_		Day, Year)			
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1	10 (3)		30. Name and address of person of Tahmina K. Ahme	ed, M.D. 8		,	Print) Sity Blvd	. Ea	ast, Si	lver :	Spri	ng, N	/d. 2	0903			
	Sta Registr		31. Date filed (Month, Day, Year)	1 2010 32. Registra	ar's Signatu	A. A	barker										
						'/											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>010</u> Physician/ March 1:50P M Helen Anne Halbig 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) 95 yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 □ M 2 🗓 F Hours Min. (Month, Day, Year) 11/22/1914 Director 506-09-5763 Iowa Usual Residence of Decedent shov rral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Alexandria Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 Yoakum Pkwy., Apt. 923 22304 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 ☐ Widowed 4 ☐ Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Government Official Federal Government vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis J. Halbig Caroline Trecker of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn C. Chaney/ Niece 3128 Stonehenge Dr., Riva, MD 21140 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 3/13/10 Clinton, Maryland Saneral Service Life 21. Signatu 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Medical resulting in death) Due to (or as a consequence of) Examiner enmonia Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the at d be detached for Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 has certificate eral Director: After this certific filled in by the funeral director, 24 hours

24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 Yes 2 No Yes 25. Was case referre to medical **8** 26. Place of Death (Check only one) examiner? Hospital Other: မှု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Date filed (Month, Day,

within 2

A19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Julia Parks Hand 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death omi 00 If Under 1 If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Year Days Min 5 (123) 1923 566-24-2352 **Director** Vîrginia 86 Usual Residence of Decedent fshow 10a. State 10b. County within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Salisbury 1 🛱 Yes 2 🗌 No Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 806 College Lane, Apt. E 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 X Divorced Specify: Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Bank Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Nottingham Preston Dix Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Nuttall daughter 3346 Blue Heron Way, Eden, Maryland 21822 20b. Place of Disposition (Name of cemetery, crematory or other place)
Anatomy Gifts
Registry 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 03 12 2010 Glen Burnie, Maryland Signature of Funeral Service Licen e 22. Name and Address of Facility Holloway Funeral Home P.A. 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MALIGNANT CARCINOMA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of signed by the attending physician and defeached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed' 2 1 No 1 🗌 Yes 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 7 No Other: Certificate: To 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tyes 2 🗆 No ☐ Accident Investigation 3 🔲 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) ′3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

(Offleram

31. Date filed (Month, Day, Year)

MAR 12

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21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALL

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32 Registrar's Signatur

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Edna Louise Hoffman 11:30 March 8, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER HARRISON SENIOR LIVING SNOW HILL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Months Days Hours 1□ M 2🏞 F 93 217-30-7706 09 12 1916 Director Maryland Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Excenting Institute 1 and 100ce. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 No Director Wicomico Salisburv Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 300 Lemmon Hill Lane 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: \$ Specify: white 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) health care registered nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be annie Hammond Ernest L. Shocklev ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1608 Swansbury Dr., Richmond, VA 23238 19a. Informant's Name/Relationship (Type. Print) Stanley Rayner nephew 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3 11 10 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dcensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HTHEROSCLEROSIS LORONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner if criy, leading to mine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760. attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 217 No 3 Probably 4 Unknown 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an page 2 s has autopsy certificate 2 200 1 🗀 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of pertities 29c. License number 29d. Date signed (Month, Day, Year) MD) 000 62172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARKET ST. POCOMOKE CITY MD 21851. 1604 MD 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

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State

31. Date filed (Month, Day, Year

PT

32. Registrar's Signature

10-02242

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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)		4a. Facility Name (if not institution		mber)		4b	. City, Tov	n, or La	cation of	Death			ounty of De	eath			
	Ħ	2110 Stonegate Boule	vard				Elkton					Ced					
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birtho	lay)	If Under	$\overline{}$	If Under	24Hrs. 8 Min.	B. Date of B	irth(MM/DD	/YYYY) 9. Fc	. Birthpla oreign	ice (State or		
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	John Glazik	,,						Do1o	res	es Olsen						
D 21215-003 should be filed within and Mental Hygiene. T is marked other till natic event, the Mediatic ev	ᆰ	19a. Informant's Name/Relations	hip (Type, Print)		19b.	Mailing	Address	(Street	and Numb	er or Rur	al Route Nu	ımber, City	or Town, S	State, Zip	Code)		
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e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Them 27 is marked other than "natural", or items 23a or 28a-f she reraumatic event, the Medical Examiner must be notified at once	1	20a. Method of Disposition			Place of	Disposit	ion (Name	of ceme	etery,		Date /2010		cation - Cit	ty or Tov	vn, State		
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		30. Name and address of person				v. C	<del>-                                    </del>										
		Theodore M. King, J		tant Medical		iner	111 Pe	nn Str	eet, Ba	Itimore	, MD 212	201					
	1000	31. Date file (Mah Pay Yes	32.	Registrar's Signa	ature 🥖	- 10	1										

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 3 Vear **Physician** JOHNSON HOT HELEN 3:12 AM 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 330 THELMA AVENUE GLEN BURNIE Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Days Hours Delaware 219-14-185 85 Director 7-24-24 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting must be notified at once. 1 ☐ Yes 2 X No Director Maryland Cecil Port Deposit 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21904 736 Principio Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2¥∑No Specify: þ Specify: WITE 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery Ward College (1-4or 5+) Elementary/Secondary (0-12) Baltimore, Maryland Claims Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry W. Bailey Mildred E. Steele ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 736 Principio Road, Port Deposit, Maryland James W. Hornberger (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Asbury Cemetery 03/15/10 Port Deposit, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licen Dhomes M. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** demen disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed SEIZURE DISORDER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an ナッ 1 ☐ Yes 2 No BRAIN Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R171311 CKW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE SUITEG D.L. COLEMAN, CRNP 705 DIGITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#4b PerPhys PCC3 Certificate of Death Reg. No. 2. Date of Death Month 03 Day 10 Year Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 M 2 D F Months Min 2 Director Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No HING 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral SA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced RUACK Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) AR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willie 19a. Informant's Name/Relationship (Type, Print) Mother -19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BANGOR 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 103-20-2010 SUITLAND 22. Name and Address of Facility PHILLIP MOKE ISSETTE - JOHNSON 4902 STAN HAVEN R BELL SR. AND WINDWA 21. Signature of Funeral Service Licensee any Phillip TEMPLE HILLS MIN 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in deeth). Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed NA Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 200 욘 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 ☐ DOA . Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident
Suicide Investigation after deat Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide filled in by determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature nd title of 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 12 32. State 5 2010 Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland State of Maryland		rtment of H tificate of L		_	Reg. No.	0	09398
	Dhysiair	an.	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Mary I. Jones				March	6 20	010	1456 M
	Examin	er	4a. Facility Name (If not institution, give street and number)	_	4b. City, Town, or			4c. County		un do 1
	Funeral		Anne Arundel Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. las		Annap If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		undel  place (State or Foreign
	Director		214-40-0051 ¹□м²¤F 73	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da July 1	7 ^{re} 1 936	Ma	place (State or Foreign ntry) ryland
	and		Usual Residence of Decedent  10a, State 10b, County 10c, City,	Town or Loc	eation				1	0d. Inside City Limits
	Maryl f sho	ţ		napo	lis					1 □Yes 2 No
	r 28a	irec	10e. Street and Number		10f. Zîp Code			10g. Citizen of W	/hat Cour	ntry?
	th with	Funeral Director	704 Bywater Rd.		2140	1		USA		
	r deal	nuel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Race Black	e - Americ k, White,	can Indian, etc.
0030	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, I've Medical Evand was roughly to milling at	δ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ XNo If Yes, Give Year or Dates:	1	□Yes 2XINo	Specify:		Specify:	В1	ack
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yiand	ld be lental ked o ic eve	To Be	Alexander Offer			Cora T	asker			
ary	shou and M s mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numb	er, City or Town,	State, Ziç	Code)
Ğ.	es 1 and 2 of Health a f item 27 is r other tra	1	Cora Jones-Hall(Daughter)		Bywater			is, Md.		
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Dailimor	it. Partmen rtant; njury		(, ,,		1 Park		1-10	Annapo		, Md.
ם	permit. Pages 1 Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee  Janny L, Reese MODY83		mameRe⊱edes 21 West					01
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	7 0.7	(6)					Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequent	nce of):						
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ב ב	e law has b je 2 st	Completed					24a. Was auto	psy programmed?	Vere auto prior to co death?	opsy findings available impletion of cause of
5	n; Th ificate or, pag	e Co	25. Was case referred to medical				1 ☐ Yes	2.23No 1	Yes	2 □No
5	ysicia s cert directo	To Be	examiner?  1 Yes 2 No  Hospital: 1 Appatient 2 EF	R/Outpatien	t 3 DOA Othe	26. Place of Dea		dence 6 ☐Othe	er (Sneci	
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200	tendir eath. or: Ai the fu	catic	2 Accident investigation		M 1 🗆 Y	Yes 2 □No				
	or At after d Direct I in by	Certification:	3 ☐ Suicide Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location ( City or To	Street and Numbe wn, State)	ər or Rura	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death statement. To the Funeral Director: After this certificate has been signed by the attending to the Funeral Director. After the completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier (Check only  Medical Examiner: On the basis of examinatio	edge, death	occurred at the tin	ne, date and place	e, and due to the	cause(s) and ma	anner as :	stated.
	the Hi thin 24 the Fi	Medical	one) and manner stated.	m and/or in	29c. License		ined at the time.	29d. Date signed		
	<b>₽</b> ₹ ₽ 8		29b. Signature and the of ceptiller		Dr	518	7	3/	110	
(	110		30. Name and address of person who completed cause of death (Item 2	1	11	11	MI	3/6	0	
	Sta	te	31. Date filed (Month, Day, Year) 32. Fegistrar's Signatur		are	nd c	1170	ical	10	7 106
	Registr	ar	MAR 12 2010 Server A	1. 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** 7:20 а м Elizabeth Jane KENDLE March 14 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Williamsport
Inder 1 Year | If Under 24 Hrs Williamsport Retirement Village Washington 8. Date of Birth (Month, Day, Year)

June 28 1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🗓 F 89 Director Maryland 214-74-4335 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be redified at Director 1 □Yes 2√□No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 19717 Cool Hollow Road 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify ₽ Specify: White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ion of Health and Mental Hygiene. nt: If item 27 is marked other than "I y or other traumatic event, I'm Med y or other traumatic event, I'm Med Elementary/Secondary (0-12) College (1-4or 5+) 11 0 Homemaker Her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roger Sinnisen Nora Easterday ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Kendle, Jr. - Son 20023 Lappans Road, Boonsboro, Md. 21713 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 3/18/2010 | Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Juneral Service Licenses Balul JS) 62 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUSTE RENAL FAILURE 5.DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 5-DAYS ACUTE VIRAL GASTROENTERITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician; The law requires that the death certificate be executed Due to (or as a consequence of) burial-1 Box 68760 Physician/Medical the as attending IF FEMALE for use If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ned by the a 9 I Inknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ SENILE DEMENTIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐Yes 2 ☐No investigation 24 hours after death. Funeral Director: / 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

E.

31. Date filed (Month, Day, Year)

HOWE

ARTIZAN

154 N.

Redistrar's Signature

, WILLIAMSPORT.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2010 March 10:03 A M 14, Richard Nelson Liller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 9045 Jordan Road Fairplay If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 25, 1932 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**XX**M 2□ F 77 220-30-9335 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov or other traumatic event, the Medical Examiner is ust be notified at 1 ☐ Yes 2XXNo Director Maryland | Washington Fairplay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 9045 Jordan Road 21733 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 125 Aves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1953-1 Never Married Married If Yes, Give Year or Dates 1 ☐Yes 2XXNo ģ 1955 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Millwright Truck Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Bointon Liller Florence Elizabeth Wilson ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 9045 Jordan Road Fairplay, MD 21733 Barbara A. Liller - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify Greenlawn Mem. Park 03-17-2010 Williamsport, Maryland 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Furleral 89 Williamsport, MD 21795 425 S.Conococheague St. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Revel **Physician** un kuru disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending n 24 hours after death.

ne Funeral Director: A nietely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical the within To the 29b. Signature and 29d. Date signed (Month, Day, Year) D47288 03, 16, 2010 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) Oak Hill ave; Hagerstown, MD 21742 Shaheen 112821

5H 4+1

Baltimore, Maryland 21215-0036

Box 68760.

P.O. I

Division of Vital Records,

State Registrar 31. Date filed (Month, Day,

Year

MAR 16

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09401 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3/2/2010 Physician/ Elizabeth B. Leonard 1:45pm M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Ginger Cove Health Center Annapolis Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Months Davs Hours (Month 22 / 1924 Director 579-26-4349 85 PA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 😾 No Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9101 River Crescent Dr. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1XXYes 2 □ NoKorea Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2XXNo Specify: If Yes, Give "natural", Specify Completed XX Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Admitting Clerk Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland Charles William Blessley Mabel Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 South Cherry Grove Ave #304 Annapolis, MD 21401 Philip Leonard Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 3/6/2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Other (specify) Month Day Year signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Investigation 2 No Accident within 24 hours after de To the Funeral Directo completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the last of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example or in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of Certifying Norse Practioner; of the best of my knowledge, death occurred at the time, date and place, and due to the cause of an anner as stated. 29a. Certifier examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, the best of my knowledge, death occurred at the time, date and clace, and due to the cause is and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year,

State Registrar ess of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

iled (Month, Day, Year)

MAR 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 9. Day 2010 ear Physician/ John F. Leitch 9:50 AΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Hours 12/14/1923 1 M 2 D F Director 86 219-12-4013 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Mitchellville 1 Yes 2 No MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10450 Lottsford Road 20721 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 1943-45 3 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Leitch Lula Phelps permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard H. Leitch/Son 7800 Inverton Road #T2, Annandale, VA 22003 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Thomas Episcopal 03/16/2010 Upper Marlboro, MD 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Pa (1. Inter the dis ace, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failur. List only one cause on each line. Approximate Interval Between Imm Hate Cause (Fin 1) Onset and Death Intracerchia Physician/ disease or condition resulting in death) Medical Examiner S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the hurial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 1 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital 1 ☐ Yes 2 ☑ No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. D0069669

Registrar
DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

HOSpital Dr. Cheverly, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ANUPAMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Winston Thomas Mann March 21, 2010 8:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 🗆 F 491-32-6167 79 Hours Iowa September 30, 1930 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Frederick Adamstown 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7910 Hope Valley Court 21710 United States of America permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items: amy injury or other traumatic event, the Medical Examiner musonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 □ No 1952-Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 1953 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Construction Manager Veterans Administration Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winston Shuah Mann ဂ Maxine Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Mann / Wife 7910 Hope Valley Court, Adamstown, Maryland 21710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Resthaven Memorial Gardens March 24, 2010 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facilit Keeney & Basford P.A. Funeral Home 106 Fast Church Street, Fredercik, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death s been signed by the sahould be detached in 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 100 ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Director: A Accident Investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours a within 24 hou

To the Fune

completed file

> Casper E. Cline, M.D. State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signature and title of certifier

300 West Ninth Street, Frederick, Maryland 21701 Pregistrar's Signature

3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D16428

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 March 13 Elizabeth C. Martin 11:25p^M⋅ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Oakland Nursing and Rehab Center Garrett 0akland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🕅 F Months Hours 78 May 6, 234-42-9847 1931 Keyser, WV Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Cut-Off Road HC 84, Box 11-A 26726 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify 3 ☐ Widowed 4 👿 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Hospital Dietary department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elijah VanMeter Virginia Blizzard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Snyder/Daughter 26726 HC 84, Box 11-A Keyser, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Keyser, WV 4 ☐ Donation 5 ☐ Other (Specify) Cabin Run Cemetery 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final omit disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

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**Physician** 

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

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or Attending Physician: The law requires that the death certificate be executed

Hospital

Division of Vital Records, P.O. Box 68760,

autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

(Check only

one)

29c. License number 1712333

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 15110

1 ☐ Yes

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Garrett Medical Group 311 N. Fourth St. Thomas Johnson, M.D. Oakland, MD 21550

State Registrar 31. Date filed (Month, Day, Year) MAR 25

32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mo.

ORIGINAL

Registra

Physician /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Ex-miner must be notified at anones.

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

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	Western Maryland 5. Social Security Number 6. Se		Center		gerstow 1 Year   If Und	er 24 Hrs.	8. Date of Birth	Washing 9.Bi	ton
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	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	or Location					10d. Inside City Limits
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irec	10e. Street and Number			10f. Zip	Code		1	0g. Citizen of What C	Country?
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une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 X Yes 2 □ N	Ever in U.S.	13. Was Deced If Yes, spec	ent of Hispanic ify Cuban, Mexi	Origin? (Sp can, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
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To B	J. Thurman Mowen				М.	Cathe	erine Bas	sore Mowen	ı
	19a. Informant's Name/Relationship (T	ype. Print)		-	•			City or Town, State,	. Zip Code)
	Donald Mowen-son  20a. Method of Disposition					hrews	bury, PA	A 1/361 20c. Location - City of	or Town State
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	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address								
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Completed by Physician/Medical E	230. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	pf pregnancy 2 ☐ Fetal death	3 □Ectopic pr	egnancy			23d. Date of d	
/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown		5 ☐ Other (sp				Month	Day Year
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Medical Certification:	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination and/	death occurred or investigation	at the time, date, in my opinion,	and place death occu	e, and due to the curred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
Me	29b. Signature and title of certifier		m t	290	License numbe	er 1 1 1	2	9d. Date signed (Mo.	
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State Registrar



Hagerstown, MD 21742

1500 Pennsylvania Avenue

31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Zephaniah Mullings March 1735 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4101 Stoconga Dr. Prince Georges Beltsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 ÅM 2 □ F Jamaica Min. 218-06-1876 Days Hours 1 1/7/1948 61 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Beltsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4101 Stoconga Dr. 20705 Jamaica 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗷 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married **Black** 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Heavy Duty Mechanic Conquip Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Slvester Mullings Violet Farquharson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esmena Mullings/ Spouse Beltsville, MD20705 4101 Stoconga Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mullings Family Cem. 4 ☐ Donation 5 ☐ Other (Specify) 3/28/2010 St. Catherine, Jamaica Signature of Funeral Service Licensee 22. Name and Address of Facility Marshalls Funeral Home 4217 Ninth Street, NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Heart Disease Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 - Ectopic pregnancy Year 5 Other (specify) Day Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires I within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner∉ 1 Yes 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury 2 Accident 2 🗆 No Investigation 1 Tes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who

Day, Year)

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

**Division of Vital** 

impleted cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3:50p M Maurice S. Meyer March 09. 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Renaissance Gardens - Riderwood Prince George's Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) Days Hours Months 1 **X**M 2 □ F 147-05-8313 93 12/26/1916 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 👿 No Maryland Prince George's Silver Spring 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 20904 3128 Gracefield Road, #623 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1943-1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 1945 Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Attorney I au 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Meyer Anna Perlman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan G. Meyer - Daughter 7505 Democracy Blvd., #332, Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorah Gardens 03/11/2010 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. KAR 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Days Pneumonia disease or condition resulting in death) Due to (or as a consequence of): Years Dementia Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 Tes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show

within 72 hours after

12 should be filed within 7 h and Mental Hygiene.

Pages 1 and 2 should be nent of Health and Mental

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital

Director

Funeral

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Completed

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certificate be executed and burial-trar attending physician the use for the þ signed has certificate funeral ne Hospital or Attending P n 24 hours after death.
The Funeral Director: After t pletely filled in by the funeral After 1

Physician/Medical

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Completed

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Certification:

Medical

State

Registrar

29a. Certifier

Hypertension

25. Was case referred to medical examiner? 1 Yes 2 No

> investigation 2 Accident 3 Suicide 6 Could not be determined 4 Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

X Nurse CRNP manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Citherine 31. Date filed (Month, Day, Year)

MAR 12 2010



within 24 hou To the Fune completely fi To the

2+

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ARLENE MORGAN MARCH 2010 11:12 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 T F Months Days Hours Yrs 216-58-8870 Director 56 FEB 5 1954 WASHINGTON, DC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it is Medical Examinar must be notified at 1 X Yes 2 ☐ No Directo MD PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Numbe 10g. Citizen of What Country? death with 1117 CAPITOL HEIGHTS BLVD Funeral 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after of teatth and Mental Hygiene. m 27 is marked other than "natural", or iten 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 3 1 ☐ Yes 2 No Specify Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SERVICE TECHNICIAN <u>PRIVATE</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS MORGAN DOLORES DRAKE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau JAMES MORGAN/SON 1117 CAPITOL HEIGHTS BLVD CAPITOL HEIGHTS, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY 3/15/2010 RIVERDALE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac disease or condition resulting in death) Fatal /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a consequence of) attending physician and for use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a P.O. ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown should Diabe 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy certificate 2 **X**No 1 ☐ Yes 2 ⊋No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 5 ☐ Pending investigation neral Director; A filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of

Dr. Griffu

vho completed cause

avis

Hospital Drive

Cheverly

MD

of death (Item 23a) (Type, Print)

3001

		•	For State Registrar		State of	Marylan				ieaith a Death	ina ivi	entai Hy	/giene Reg. No.	201	0	09410
	Physici /Medic		1. Decedent's Name Rhoda	(First, Middle, Las Irene	McKenz	ie						2. Date of Do Month March		2010 ^Y	ear	3. Time of Death <b>7:38 PM</b> M
-	Examin		4a. Facility Name (If Fort Wash				•			Location of <b>shing</b> 1			Pri	nce (	Death Georg	ge
	Funeral Director		5. Social Security Nu. <b>242–68–72</b>	31	ex □ M 2 <b>X</b> F	7. Age (In yrs. 88	last birthday) Yrs.	If Unde Months		If Under 2 Hours	Min.	8. Date of Bi March March	4, 192	22 No	Birthpla Countr Drth	ace (State or Foreign Carolina
	e Maryland 8a-f show	ector	MD.	Prince G	eorge		y, Town or Lo									d. Inside City Limits 1 <b>X</b> IYes 2 □ No
	th with the 23a or 2	Funeral Director	10e. Street and Numi 15701 Ma	ple Driv	e			10f. Zip					-	zen of Wha ed Sta		ry?
920	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Mydical Exam in a useful to highlind at e.e.	by Funer	11. Marital Status 1 ☐ Never Marrie 3 🛣 Widowed 4		12. Was Deced Armed Ford 1  Yes 2 If Yes, Give Year or Da	ces? 2 [A] No e		Was Dece f Yes, spe 1 □ Yes		ispanic Orig in, Mexican, Specify:	gin? (Spe , Puerto I	cify Yes or N Rican, etc.)		14. Race - Black, \ Specify:	America White, etc <b>Bla</b> (	c.
Maryland 21215-0036	I within 72 ho jiene. r than "natur the Medical	Completed by	(Special	15. Decedent's Ed y only highest grad dary (0-12)	ucation de completed) College (1-	4or 5+)	16a. Deced (Give life. I	kind of wo DO NOT u	rk done d se retired	ation during most l)	of workir	ng		nd of Busin		
/land	2 should be filed v n and Mental Hygie Is marked other t raumatic event, th	To Be C	17. Father's Name (F	irst, Middle, Last) <b>tkins</b>						18. Mother		(First, Middle Spar		Surname)		
	1 and 2 sho Health and I tem 27 Is ma		19a. Informant's Nar Carolyn	ne/Relationship (7 Woodhous	_	nter)						Route Num			ate, Zip (	Code)
Baltimore,	permit. Pages 1 a Department of He Important: If Item any Injury or othe		20a. Method of Dispo		Removal from S	20b. F	Place of Dispo emetery, crem thwood	sition (Name of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of the latery of	me of other place eter	y 3,	□ /10/2	ate 2010	20c. Lo	cation - Cit	•	
Balt	permit. Pag Departmen Important: any Injury once.		21. Signature of Fain	eral Service icen	see // //	ND119						tt Fun n Rd. 1			1D. 2	20601
	Physician /Medical Examiner		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List only	a. Acu	ch line.	4000								1 1	Approximate Interval Between Onset and Death
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list condification, leading to immicause. Enter Underlicause (Disease or in that initiated events resulting in death) La	ditions, lediate ying jury	c	r as a consequ	, 									
	The law requires that the death certifica ate has been signed by the attending ph age 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	onths?		rth 2□Feta ant at time of c	death 3	Ectopic p		y			2	23d. Date of Month		y Day Year
rds, P.	quires that I in signed by uld be deta	þ	Part II. Other signific	ant conditions co	ontributing to dea	ath but not resi	ulting in the u	nderlying o	ause give	en in Part I.				se contribi		e cause of death?
I Records,	. The law require cate has been si page 2 should b	Completed									_	perl	s an opsy formed? 2 □ No	prid dea	re autops or to com ath? Yes 2	sy findings available pletion of cause of
Vital	sician: The certificate   rector, page	Be	25. Was case referre	d to medical						26. Place	of Death	(Check only				
f V	nysic lis ce direc	To E	examiner? 1 ☐ Yes 2 🛛 N	0	Hospital: 1 ☐ In	patient 2 🗖	ER/Outpatier	nt 3 🗆 D0	Othe	or:		ne 5 🗆 Res		6 Other	(Specify)	)
ion	nding ath. r: After e funer	Certification: T	27. Manner of Death  1 Natural  2 Accident	5 Pending investigation	28a. Date o (Month	f Injury , <i>Day</i> , Yea <i>r)</i>	28b. Time of Injury	M	28c. Injury Work	y at	10	28d. Describe	how injury	y occurred		
Divi	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certifi	3 ☐ Suicide 4 ☐ Homicide	determined	building	of Injury - At ho g, etc. <i>(Specif</i>	у)					City or To	own, State,	,		Route Number,
	ne Hospi n 24 hour ne Funera	Medical (	29a. Certifier 1 (Check only 2 one)	Certifying Ph	ysician: To the bainer: On the ba	sis of examina	wledge, death	h occurred vestigation	at the tin	ne, date an pinion, deat	d place, a	and due to the	e cause(s) e, date and	and manr place, and	ner as sta d due to t	ated. the cause(s)
	To th within To th comp	M	29b. Signature and ti	tle of sertifier	11			290	c. License	e number			29d. Dat	e signed (i	Month, D	ay, Year)

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO053117

10

Certificate of Death Reg. No. 2 1 1 1

Physician
/Medical
Examiner

091.11

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm "widted East that rotal to notified at appear.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

Division of Vital Records, P.O. Box 68760,

	1 Decedent's Nome	Time Adiabath A								. NO.C.	1 0	700	
n al		e (First, Middle, Last nn Marste:	•						Date of Death Month 3/8/	2010	Year	3. Time of 1554	Death M
er		f not institution, give ndel Medi	street and number)	c		4b. City, Town, c	r Location of D Annapo			4c. County An		rundel	
	5. Social Security No. 577–42–78	856	7. Age ☐ M 2 <b>.Cx</b> F	e (In yrs. las 77	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Viin.	Date of Birth (Month, Day, Ye 2/18/19	9333	9. Birtl	hplace (State of untry) DC	r Foreign
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jo	MD	Anne Arı	unde 1			st River						1 ☐ Yes	•
irec	10e. Street and Nun				110	10f. Zip Code			10g	. Citizen of \	What Cou		
a a	914 Judge	e Court Ea	ast			2	0778				USA		
nue	11. Marital Status		12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H	lispanic Origin' an, Mexican, P	? (Specify	Yes or No-	14. Rac		rican Indian,	
Be Completed by Funeral Director	1 Never Marri	ed 🔏🙀 Married 4 □ Divorced	1 ∐Yes 2 N If Yes, Give Year or Dates:	lo	- 1	□Yes 🛣 No	Specify:		, ,	Specify		White	
eted	(Spec	15. Decedent's Edu ify only highest grad	ication		16a. Deced	lent's Usual Occup	nation	working	16	b. Kind of B	usiness/l	ndustry	
ğ.	Elementary/Secon		College (1-4or 5-	+)	life. L	OO NOT use retire	d) -	working					
ပ္သ	12 17. Father's Name (	(First, Middle, Last)			Rec	ords Cle		Name (Fi	rst, Middle, Mai			Title	
o B	James W.							•	L. Bran		16)		
		me/Relationship (T)	,			g Address (Street							
	Robert Mai		Spouse			udge Cou							
	20a. Method of Disp 1X Burial 2	osition □Cremation 3 □ F	Removal from State			sition (Name of natory or other pla	1	Date		c. Location -			
		5 Other (Specify)		Lake		Cemetery  Name and Addre			010 Da			•	
	) from	Men Lice Lice Is				Ridgely			-			, P.A.	
	23a. Pari 1. Enter to shock, or he is	ne sease, or complete silure. List only of	ications that caused ne cause on each lin	the death.	Do not ente	er the mode of dyi	ng, such as car	rdiac or re	spiratory arrest			Approximate Interval Bety	veen
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	resulting in death		Du to (or as a	consequer	nce of):							-	
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Examiner	Sequentially list con if any, leading to im- cause. Enter Under that initiated events		c	,									
	resulting in death) L	ast	Due to (or as a	a consequer	nce of):								
edic			d										
an/Medical	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome of	of pregnanc	y o	Ectopic pregnanc				23d. Da	te of deli	ivery	
_	in the past 12 i	months?	4 ☐ Pregnant at			Other (specify) _	У			Mo	onth	Day Y	ear
Physic	9 Unknown	icant conditions co	ntributing to death bu	it not reculting	na in the	iderlying cause of	en in Part I	= 1	23a Did tohoo	TO USE COST	ribute to	the cause of de	aath?
Completed by	Lyn	nhome		it not resulti	ig in the til	denying cause giv	en in Fait i.			2 No	3 □ Pro		nknown
ete	Control	te ven	(	110					24a. Was an				
티	امرا	1 6	Tal y Cal	المحد				-	autopsy performe	d?	prior to d death?	topsy findings a completion of ca	use of
Be C	25. Was case refer	ed to medical		<del></del> -			26. Place of	Death (C	1 ☐ Yes 2 ↓ heck only one)	No	1 ∐Yes	2 🗆 No	
0	examiner? 1 ☐ Yes 2 🔼	N 1	lospital:	nt 2 EP	R/Outpatien	t 3 DOA Oth	or:		5 Residence	e 6 Oth	ner (Spec	cify)	
ion	27. Manner of Death	5 ☐ Pending investigation	28a. Date of Injur (Month, Day		Bb. Time of Injury	28c. Inju Wor M 1	yat k? Yes 2 □ No	28d.	Describe how	injury occur	red		
lica	2 ☐ Accident 3 ☐ Suicide	6 Could not be determined	28e. Place of Inju	ry - At home	e, farm, stre		Tes 2 1140	28f.	Location (Stree	et and Numb	er or Ru	ral Route Numl	ber.
Cert	4 Homicide	dotermined	building, etc	. (Specify)		,			City or Town, S	State)			
Medical Certification:	29a. Certifier (Check only one)	edge, death n and/or inv	occurred at the ti	me, date and popinion, death of	place, and occurred a	due to the causat the time, date	se(s) and m e and place,	anner as and due	stated. to the cause(s)				
Me	29b. Signature and I	title of certifier	1			29c. Licens	e number		29d	_		, Day, Year)	
	1/4/	1 lete	up ,	M.		0	2804			3-0	7	2010	
Ì	30. Name and addre		ompleted cause of de				. A	uno,	2/1	MB	310	c1	
е	31. Date filed (Mont	h, Day, Year)	32. Registra	r's Signature	e	AAMO		0	acies	141)	216		
r	8	MAR 1020	110 Dense	m d	4 1	a Kel							

DHMH 17 Rev 1/2001

State

Registrar

0-01810 Matthew Bishop		Please Type or State of	Maryland / De	partme	ent of Health ar	id Men	ital Hygiene	21		09412
		1- For State amend#20A, B Per F Registrar 1. Decedent's Name (First, Middle, Last)	H, 3/12/09 (	Certifica	te of Death AA	CO HEA				0.7
Physici Medical Exami		Matthew Bishop Mc	Donough				2. Date of De Month March 3,	Day `	Year	3. Time of Death 1041 hrs
		4a. Facility Name (if not institution, give str 100 South George Street	eet and number)		4b. City, Town, o Cumberlan				ty of Death	
Funeral Director		5. Social Security Number 6. Sex 219–23–9944 1X M	7. Age (In y	rrs. last birth	day) If Under 1 Yes Months Day				Cou	nplace (State or Foreigr ntry) Cyland
any		Usual Residence of Decedent 10a. State 10b. County	10c. (	City, Town o	r Location			· · · · · · · · · · · · · · · · · · ·	<del></del>	10d. Inside City Limits
land F show	or	NY Onondaga		Manli	ius					1 Yes 2 No
the Mary or 28a- tiffed at	Director	10e. Street and Number 3837 Oran Delphi	Rd.		10f. Zip Code 131(	)4		10g. Citizen of USA	What Count	ry?
eath with i items 23s	Funeral I	11. Manital Status 12. Married 2. Married	2. Was Decedent Ever i Armed Forces?		13. Was Decedent of Hi	spanic Orig	gin? ( Specify Yes or N , Puerto Rican, etc.)	lo- 14. Ra	ace - Americ hite, etc.	an Indian, Black,
rs after d ural", or miner m	ð	3 Widowed 4 Divorced If Y	es, Give Year 2006	<b>–10</b>	1 Yes 2 No			Specif	v Whit	
16 n 72 hou nan "nati ical Exa	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		uring most of working life	e. DO NOT		Tob. Kind of	Dusiness/iii	uusiiy
5-003 ed withi tygiene. other th	Comp	17. Father's Name (First, Middle, Last)	4		Soldie		's Name (First, Middle		Resei	rves
21215 1d be fill Mental H narked event, t	Be	Phillip N. McDonoug		T10h	Mailing Address (Stre		ria L. Luz		our State	7in Codo)
MD 2 d 2 shou lth and h n 27 is n	To	Phillip N. McDonoug	h / father	38	337 Oran De	lphi 1	Rd., Man	lius, N	Y 1310	)4
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hearlst and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State	0b. Place of cremator	Disposition (Name of certy or other place)	emetery,	Date 3/11/2010	20c. Location	on - City or T CUSE ,	
Baltir Permit. I Departmo Importa injury or		21. Signature of Funeral Service Licensee	4		22. Name and Addres	s of Facility	Beall	Funeral	Home	
Physician		23a. Part I. Enter the disease, or complicate failure. List only one cause on each l	ions that caused the de	eath. Do not	6512 NW (			OWIE, M		Approximate Interval Between Driset and
/Medical Examiner		Immediate Cause (Final disease a. As	phyxia due to Har to (or as a consequence							Death
	Jer		to (or as a consequent	ce of):						
d sit	xamine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	to (or as a consequen	ce of):	·					
executed ian and al - trans	ical E	dd	MENDED			-				
760, ficate be g physicist the buri	/Med	IF FEMALE: 23b. Was decedent pregnant in the	3c. If yes, outcome of p		Fetal death 3	Fetonic	c pregnancy	23d. Date	of delivery	ıy Year
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Puncral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Medical	1 Von 2 No 0 Holmour	Pregnant at time of	of death 5	Fetal death 3 Other (Specify)		ргеднансу	World	ı Da	iy real
that the ced by the detached	by Ph	Part II. Dther significant conditions con	ntributing to death but n	not resulting	in the underlying cause	given in Pa				e cause of death?
ds, Frequires	eted					_	24a. Wa		o. Were auto	ppsy findings available
Recor The law ate has bage 2 sh	Completed						perf	opsy ormed? 2 No	prior to co death? 1  Yes	mpletion of cause of 2 No
cian: Certific	Be C	25. Was case referred to medical examiner?	ital: 1 Innetiont 2			of Death Other	(Check only one)			
of Vi g Physi ter this eral dir	٠. ح	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury		tpatient 3 DOA	ry at Work	Nursing Home 5	Residence 6		Scene
Division of Vital Records, P.O. ral or attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	1 Natural 5 Pending Investigation	FOUND: Mar 3, 2010	FOUN 0000	ND: 1	Yes 2	No Subject for	and hanging		
28e. Place of Injury - At home, farm, street, factory, or street in the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last of the last o							or Town,	State)		al Route Number, City nn , Cumberland , M
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	Me	29b. Signature and title of certifier	<u>d manner stated.</u>		29c. Licens	se number		29d. Date si March 4,		h, Day, Year)
		30. Name and address of person who com		,				<u></u>		
	tate	Ana Rubio MD. Assistant I	Medical Examiner  32. R gistrar's Sig		enn Street, Baltim	ore, MD	21201			
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DHMH 17 Rev 1/2001 DCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 13, Day 2010 **Physician** Doris OLSON 7:45a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Williamsport Williamsport Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

March 13, 1914 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 96 095-32-9510 **Director** Usual Residence of Decedent within 72 hours after death with the Maryland f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Maddell Eventum in the results of Director 1 ☐ Yes 21 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2009 Rosebank Way Funeral 21742 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc 1 ∐Yes 2½ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. \$ white 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Means Injury or other traumatic event, the Means Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Welfare Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Forsgren Esther Steen Ne1s ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Dartmouth Drive, Hagerstown, Maryland Terrelyn Greszler - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March₂d70 Jamestown, New York Lake View Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 6 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Due to (or as a consequence of) burialattending physician for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No the 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR Poor 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **20**10 March 9, Beulah Mae Overturf 6:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Aug. 21 9. Birthplace (State or Foreign **Funeral** Days 447-36-6294 1 🗆 M 2 🛛 F 89 Hours Oklahoma Director Usual Residence of Decedent show 10b. County 10a, State filed within 72 hours after death with the Maryland items 23a or 28a-f sho er must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 602 Paradise Court 20877 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: White "natural" Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Avon Cosmetics College (1-4 or 5+) Elementary/Seconday (0-12) Sales Representative Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be filed thent of Health and Mental H rtant: If item 27 is marked ot njury or other traumatic ever ည Flovd Edwards Lottie Niccum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy O. Langston (Daughter) 602 Paradise Court, Gaithersburg, MD 20877 3altimore. 20b. Place of Disposition (Name of cametery, crematory of other place)
Chape Hill
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 03/15/2010 Oklahoma City, OK Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home, M00689 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Par in Friter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Imme late Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, is any, leading to immunity cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No q 🗌 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation, Hypertension, Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown page 2 should 24a Was an Was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🌁 No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69129 DI March 9, 2010

State Registrar 9901 Medical Center Drive, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jason M. Prior, M.D.,

12

31. Date filed (Month, Day, Year)

MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John C. Opilla 2010  $P^{M}$ March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel Medical Center Anne Arundel 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year
Aug. 24 Birthplace (State or Foreign Country) **Funeral** TXM 2 F 182-34-2184 Director 65 1944 Pennsylvania Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1. XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with t and Mental Hygiene. is marked other than "natural", or items 23a Funeral 23 Madison Place 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married XX Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 4 Contracts N.S.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth Spock Michael Opilla 19a. Informant's Name/Relationship (Type, Print)
S. Jean Ulmer Opilla/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Madison Place Annapolis, Maryland 21401 permit. Page 1 and 2 shand Department of Health an Important: If item 27 is Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crematory 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial XXCremation 3 Removal from State 3/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed the burial-transi Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death been signed by the a should be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 2 NO 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 FER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending safter death.

Director: Aft
d in by the fur work? 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 000(6529 ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>010</u> Physician/ MARCH 17 **Phillips** 15:45 Frances Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY WMHS - REGIONAL MEDICAL CENTER CUMBERLAND If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ື1<u>934</u> Min Jan 13 Days Hours Director 220-32-4875 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural" any injury or other traumatic average. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director PA Bedford Bedford 1 Yes 2 X No 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? Funeral Route 3 Box 645 Pine Ridge Road 15522 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed white Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Union Rescue Mission Retired Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Harry Glenn Phillips Elrose Elizabeth (Schaffer) Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 Patricia Phillips sis. in-law 525 Caroline Street Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Hillcrest Memorial Park 3/20/2010 Cumberland MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Servi 22. Name and Address of Facility Part Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition resulting in death) Medical **Examiner** END STAGE OBSTRUCTIVE LUNG Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examiner physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregpent 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has e 2 autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No s certificate has lirector, page 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 Yes 2 🗗 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural Pending Director: A 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier within 24 hou

To the Fune

completed fi Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number ATH gus Semo D14865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBUSTIANO, MD, 200 GLENN STREET, SUITE 302, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

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Box 68760

P.O.

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Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 28 2010 FEBRUARY LAMONT PAYNE 10:41 **Medical** 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 ፟፟፟ M 2 □ F Months Hours Min Director 30 WASHINGTON.DC 577-08-1660 1979 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 □ No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10g. Citizen of What Country? Funeral 225 WEYMOUTH STREET USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: BLACK Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12TH ENTREPRENEUR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ၉ JAMES G. PAYNE MARIE V. BOTTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTJUAN RICO PAYNE/BROTHER 5631 PARK DRIVE BOWIE, MARYLAND 20715 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ 5 20b. Place of Disposition (Name of cemetery, crematory or other place)
RIVERDALE CREMATORY 20c. Location - City or Town, State 3/10/2010 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral & ervice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME LANDOVER MARYLAND ROAD or complical multiple that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest and one cause of each lin 23a. Part 1. Enter the Approximate Interval Between Onset and Death shock, or heart failure. Li Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Exami ng physician and as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Dav Year been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform 1 ☐ Yes 2X☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending ours after death.

neral Director: Af
I filled in by the fu 1 Yes 2 🗌 No Investigation Suicide Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

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32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Year Vicente Perdomo 1:20 March 6. Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number 6. Sex 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Hours Gountry)
Puerto Rico 581-22-6207 Director 82 Yrs February Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director must be notified 1 X Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 20782 USA 3801 Powhatan Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 0 Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 2 X No Baltimore, Maryland 21215-0036 1 🖾 Yes 2 □ No Specify: Puerto Rican If Yes. Give "natural", Specify: Hispanic 3 Widowed 4 Divorced Year or Dates other than "natul ent, the Me ical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Delivery Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ္ Jose Antonio Perdomo Josefa Hernandez-Perdomo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 t; If item 27 is Petrona Perdomo / Wife 3801 Powhatan Road, Hyattsville, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of cemetery, crematory or other place)
Parklawn Cemetery 1 X Burial 2 Cremation 3 Removal from State 3/12/2010 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue RAY ROSANS Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ysician and e burial-transit Cause (Disease or iinjury that initiated events History of CVA Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 phys the L nding p. se as ti IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) 2 No by the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure to Thrive 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was autopsy performed? 24a. Was an certificate ha 2 🗆 No 1 T Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🕱 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Prantioner: To the best of my knowledge, death oncomed at the time, date and place, and due to the o 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) halle D60826 3/8/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

MAR 1 2 2010

Kshama Garg, 13332 Deerbrook Drive, Potomac, MD 20854

32. Regis a r's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Raymond Ricardo Pierce 2010 <u>10:5</u>8a[™] Medical March 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** M 2 🗆 Director 578541864 66 v19 1943 lWash Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 🔲 Yes 2 🗆 No MD Prince George's District Heights 10e. Street and Number 10q. Citizen of What Country? Funeral 2203 Senator Avenue 20747 "natural", or items edical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Year or Dates. 62-66 . Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Correctional Officer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl Pierce, Sr. <u>Gertrude Haves</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Gaskins/daughter 5912 Lottie Place Clinton, MD 20735 Baltimore, 20b. Place of Disposition (Name of permit. Page 1 a
Der artment of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Maryland Vet. Cem 3-30-2010 Cheltenham, MD Signature of Funeral Service Licenses 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 2294 Old Washington Rd Waldorf, MD 20601 P/rt 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart figure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ FOUR AD ENO CARCINOMA OF STAGE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** EFFUSION PLEURAL MALIGNANT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) a 🗆 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PNEUMOTHORAX 1 Yes 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 2 No Be ( 25. Was case referred to predica 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes Certificate: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Matural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tixe of certifier 29d. Date signed (Month, Day, Year) 3/10/2010 MD Name and address of person who completed cause of death (item 23a) (Type State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month MARCH Year Constance Anne Parkinson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1741 Severn Chapel Rd. Crownsville Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours 216-16-4579 Director 87 NJ Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland Funeral Director 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel Crownsville 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1741 Severn Chapel Rd. 21032 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2XXNo Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2XXNo Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd Loftus Steuart Dorothy Lena Nyce of Health and N item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond E. Parkinson 1741 Severn Chapel Rd. Spouse Crownsville, MD 21032 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veterans Cem 3/12/2010 Glen Burnie, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebraraso disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on. the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trans attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 🗌 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performe 1 Yes 2 No Yes 2 After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tes 2 No Other: မ 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No n 24 hours after death e Funeral Director: A eleted filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Man 6 08, MAN 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

MAR

egistrar's Signature

millossville mx 2408

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Physician/ 6:00 A M MICHAEL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Riva 2851 Glen Isle Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 10M 2 F Months Davs Hours Cyprus Director 84 216-34-0322 Usual Residence of Decedent . Page 1 and 2 should be filed within removed. It then to Health and Mental Hygiene. then of Health and Mental Hygiene. retart if item 27 is marked other than "natural", or items 23a or 28a-f show reart if item 27 is marked other than "hatural", or items 23a or 28a-f show rant. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Anne Arundel Riva Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2851 Glen Isle Road 21140 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates White 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/ Operator Restaurant 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Athanasis Piera Maroulla Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathe Piera/ Wife 2851 Glen Isle Road, Riva, Maryland 21140 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, St. Demetrios Cemetery 3/11/10 Annapolis, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 1.QCON Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No 2 🗆 No After this certificate 1 Yes 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Ko Hospital: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending s after death.

I Director: Aff
ed in by the ful 2 No Investigation 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral L Medical 1 Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🔲 To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar DHMH 17 Rev 7/2009 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Stephen Charles Reynolds 2010 March 10, 3:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 24 Hrs. 9. Birthplace (State or Foreign Country) District 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Yrs. 578-76-5394 45 Director 12/29/1964 Columbia Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It which it is a most be notified at anotes. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Directo Maryland| Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20877 342 North Summit United States Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Salesman **Fabrics** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Donald Reynolds Kathryn Bohnenblust 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Reynolds (Father) 6311 Kenhowe Drive Bethesda, Maryland 20817 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date March 13 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 <u>Metropolitan Crematory</u> Alexandria, Virginia 21. Signature of Euneral Service Vigensee DeVol Funeral Home RACE 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Multi Organ Failure /Medical Due to (or as a consequence of) Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Sepsis use as the burial-tran resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Ye ar Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. I Division of Vital Records. in 24 hours after death.

the Funeral Director. After thi
npletely filled in by the funeral within 24 hours a

			1 ☐ Yes 2 ☐	No 3 Probably 4 Number
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No
25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)	
1 Yes 2 No	Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing Ho	me 5 ☐ Residence 6	□Other (Specify)
27. Manner of Death  1   ↑ Natural 5 Pending  2  Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury	occurred .
3 Suicide 6 Could not b 4 Homicide determined		eet, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a Certifier 1 VCertifying Pl	veician: To the best of my knowledge, death	occurred at the time, date and place	and due to the cause(s)	and manner as stated

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Madan Hebb

D0062562

March 11, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Madhavi Hubbly M.D. 9901 Medical Center Drive Rockville, Maryland 20850

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2010 MARCH KENNETH RAY 10:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 XM 2 🗆 Days Min (Month, Day, Ye DEC 2. **Director** 1957 WASHINGTON, DC 579-84-0756 52 Usual Residence of Decedent shov 10a. State items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S CHELTENHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10304 ANGORA DRIVE 20623 USA fled within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc. ò 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: BLACK I Hygiene. other than "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH MAINTENANCE PRIVATE other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H 7 is marked ot မ ROBERT S. RAY DORA TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 si of Health a item 27 i EVERETT RAY/BROTHER 10304 ANGOTA DRIVE CHELTENHAM, MARYLAND 20623 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) HERITAGE MEMORIAL CEME 3/13/10 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ CORONARY ARTERY DISEASE Medical Due to (or as a consequence of) Examiner END STAGE RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that the death certificate be executed COLITIS that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical HYPERTENSION IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 XNo 1 Npatient 2 ER/Outpatient 3 DOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funera 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide work? 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 00066940

Registrar

State

Box 68760

P.O.

Division of Vital Records,

4408 QUEENSBURY ROAD RIVERDALE, MARYLAND 20737

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra's Sign

PING LI M.D.

8/10

10-02070	
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0-02070	Please Type or Print in Black Indelible Ink. Ensure All Copies Are L	egible.
dward Vernon Rowan	State of Maryland / Department of Health and Mental Hygiene	J
1- For State	Certificate of Death	

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		1- For State Cer	rtificate c	of Death	F	Reg. No.	0 09420
Physicia Medical Exami	an/	Decedent's Name (First, Middle, Last)     Edward Vernon Rowan			Date of Dea     Month	Day Year	3. Time of Death 1005 hrs
neulcai Exami	1101	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of	March 13 of Death	, 2010 4c. County of Deat	
7		1582 Eton Way		Crofton		Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 215–28–5211 1X M 2 F 80	,,	If Under 1 Year If Under Months Days Hours		Foreign	rthplace (State or
Director		215-28-5211   1X M 2 F   80	Yı	s.	Min. 11/09/	1929 6	ountryMaryland
any		10a. State 10b. County 10c. City,	Town or Loca				10d. Inside City Limits
Maryland 28a-f show 1 at once.	ō		Crofton				1 Yes 2 No
ne Mary or 28a-	Director	10e. Street and Number 1582 Eton Way		10f. Zip Code		10g. Citizen of What Cou United Stat	
MD 21215-0036 4 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shoumatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.	S. 13. W	21114 as Decedent of Hispanic Orig	nin? ( Specify Yes or N		ican Indian, Black,
death v	uneral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No		Yes, specify Cuban, Mexican,		White, etc.	Joan Middli, Bloom
after ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 No specify:	w- <u></u>	Specify: Whi	
2 hours	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	16a. Decede during r	ent's Usual Occupation (Give to most of working life, DO NOT	kind of work done use retired)	16b. Kind of Business/	Industry
036 ithin 7. ne. rethan	omplete	12 4	Electi	rical Enginee	er	Westinghou	ise
21215-0036 suld be filed within 72 hours Mental Hygiene. marked other than "natur c event, the Medical Exam	ပ	17. Father's Name (First, Middle, Last)		18.Mother	s Name (First, Middle,	•	
2121; hould be fill and Mental Is is marked tic event, p	o Be	Emory A. Rowan  19a. Informant's Name/Relationship (Type, Print )	19b. Mailir	ng Address (Street and Num	Thelma S		a Zin Code)
MD id 2 shoulth and m 27 is summatic		Mary Barbara Rowan - Wife		Eton Way, Cro			,_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
re, slan fHea If iten	ĺ		Place of Dispo crematory or o	sition (Name of cemetery, ther place)	Date	20c. Location - City or	
Baltimore, permit. Pages 1 as Department of He Important: If ite		4 Donation 5 Other Specify:		ematory		Baltimore,	MD
Baltimo permit. Page Department o Important: injury or oth		21. Signature of Funeral Service Licensee	22.	Name and Address of Facility	Beall Fune	eral Home e. Marvland	20715
Physician	Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart						Approximate Interval
/Medical Examiner	ı	Immediate Cause (Final disease a. Acetaminophen	and d:	iphenhydramine	e intoxicat	ion	Between Onset and Death
,=xaor		or condition resulting in death)  Due to (or as a consequence of	n):				
	Je.	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of	f):				
	aminer	Course. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last use to (or as a consequence of	():				ļ
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O, be exe slcian :	Medical			903 5/17/10 T ermE, g901 3/2	r 29/10 TT		
8760, tificate be ng physic as the buri		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregr		etal death 3 Ectopic	pregnancy	23d. Date of deliver Month	y Day Year
Box 687 c death certific the attending	sician	past 12 months?  1 Yes 2 No 9 Unknown	oth	ther (Specify)			
D. B.	Physic	Part II. Other significant conditions contributing to death but not re	esulting in the	underlying cause given in Pa	rt I. 23e. Did t	obacco use contribute to	the cause of death?
ires that the signed by the detach	d b				1 Ye	s 2 No 3 Pro	bably 4 Unknown
ords  * requi s been should	lete				24a, Was		utopsy findings available completion of cause of
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Completed					rmed? death?	
ital Recions The scertificate rector, page	Be	25. Was case referred to medical examiner? Hospital: 1 togetiest 2		26.Place of Death (			
ing Physical After this funeral dir	ို	1 ✓ Yes 2 No Prospital 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatien 28b. Time of		,	Residence 6  Othe	r. Scene
ion C tending leath. tor: Aff	ertification:	1 Natural 5 Pending F.4. 2 / 1.2 / 1.0	Fd 9:5	1□ Von 2 X	No subject	took drugs	_
ViSi or Att fler de Directe	ifica	3 V Suicide 6 Could not be 28e. Place of Injury - At ho	ome, farm, stre	eet, factory, office building, etc	c. 28f. Location (	Street and Number or Ru	ural Route Number, City
Solicide Could not be determined (Specify) found at residence Corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton, MD corofton							
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To with	Med	29b. Signature and life of certifier	1004	29c. License number		29d. Date signed (Mo	nth, Day, Year)
NH		Todo Hatter Week	-100	O.C.M.E.		March 14, 2010	
IVA		30. Name and address of person who completed cause of death (Item		Penn Street, Baltimore	MD 21201	<u> </u>	
	ate	Victor Weedn MD JD Assistant Medical Examin  31. Date filed (Mon) ARY 202 2010 32. Registrar's Signatu			-, NID Z 1ZU 1		
		MAR & Z /UIUI /2	1 1				1

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4:00^{а м} Roland H. Swingon, Jr. 16,2010 /Medical Feb. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Bay Bridge Health Care Center Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ff Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1<del>√</del> M 2□ F 55 578-72-3348 Director 8/26/1954 Washington, DC Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location rthen "naturel", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 10d. Inside City Limits Director X□Yes 2□No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 1114 Allison St NW 20011 1. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction nd 2 should be filed within slith end Mentel Hygiene.
27 le marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fitter Private Industry 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Elois O. Minor Roland H. Swingon, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 Department of Heelth ei Important: If Item 27 Ie eny Injury or other treu 20001 Washington, DC 1810 2nd St. NW Carolyn Swingon/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X8urial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Harmony Memorial 2/26/2010 Landover, MD 21. Signature of Funeral A Nice Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave. NW Washington, DC 20011 cc0278 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -hysician ACQUIRED immune /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of defivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a P.0. 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an hes autopsy performed this certificate t 1□ Yes 2□No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death Check only one Hospitaf: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: And Hospital or Attending I within 24 hours efter death. To the Funerel Director: After 1 Natural 5 Pending investigation М 1 Yes 2 No 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical Certified Nurse Practitional manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RIU3758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHIRENE BENNETT 900 VAN BUREN ST ANNAPOLIS MD 21403 31. Date fifed 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pearl Jane Silvers 2010 6:20 AM MARCH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔏 F Jan. 10, 1928 Months Days Hours Maryland Director 212-24-6404 82 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Maryland Washington Williamsport 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 16829 Hampton Road 21795 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2 🔀 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Pipe Cutter Organ Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roy Irving West, Sr. Edna Frances Shank permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Richard J. Silvers - Husband</u> 16829 Hampton Road Williamsport, Maryland 21795 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donatton 5 Dother (Specif Greenlawn Mem. Park 3-17-2010 Williamsport, Maryland neral S Osborne Adenerally Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Immediate Cause (Final Physician/ Bilatera Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Je L if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Lus to for as a vensequence of Exami or Attending Physician: The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnapi 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Day Month Year 2 No 1 Yes 2 Unknown 9 Unknown the be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy performed death? certificate Yes 2 No 1 Tes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: မ 1 Tyes 21 No 1 Inpatient ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) s after death. 2 Accident 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D53853 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10H-4 East Anticiam Street, Hagerstown HABIB CHOTANI 251

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month March 11, 2010 Year Marv Tiee Shaw 6:17 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
Montgomery Silver Spring Arcola Health & Rehab. Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) | Min. | (May 1, 1925) 6. Sex 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕱 F 237-36-7234 84 **Director** North Carolina Usual Residence of Decedent or 28a-f shov notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code must be n 10g. Citizen of What Country? Funeral 20902 USA 901 Arcola Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. ō Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √2 No Specify. Specify: Black 3 

Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ene. Elementary/Seconday (0-12) College (1-4 or 5+) t. Page 1 and 2 should be filed within trment of Health and Mental Hygiene rtant: If item 27 is marked other th njury or other traumatic event, the the Medical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Phillip Baker Roena Daniel 19a. Informant's Name/Relationship (Type, Print)
Dorothy B. Waiters/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1102 Sandy Bar Dr., Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State Metropolitan Crematory March 2010 15 Important: If any injury or Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Priysician Cardiac Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Pregnant at time of death Unknown ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia Completed 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autonsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Tes Other: 2 3 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated f ertifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year, 131 D56691 March 11, 2010 30. Name and address of person who completed car use of death (Item 234) (Type, Print) 12107 Heritage Park Circle, Silver Spring, MD 20906 Ghousia Sultana, MD

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 28f, per State 89 Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month E. Scott  $P_{M}$ 2010 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Manor Care Prince George's Largo Largo 7. Age (In yrs. last birthday) 71 yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months (Month, Day Days Min. 578-52-8163 Director 10-31-1938 South Usual Residence of Decedent 10a. State DC 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Washington 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5012 8th Street NE 20017 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceuent L.S. Armed Forces? 1 ☐ Yes 2 🛣 No Race - American Indian. Black, White, etc. 9 à 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: 3 Midowed 4 □ Divorced Specify: Black Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5 College (1-4 or 5+) Elementary/Seconday (0-12) Registered Nurse Nursing Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joshua Ford Beulah Belk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Belk-Butler ( POA ) 2010 Norlinda Ct Oxon Hill, MD 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Crematory 3/11/2010 Brentwood 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Auht the I 3401 Bladensburg Rd Brentwood, MD 20722 23a. Part 1. Ent. I the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or loart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hip Fracture Fall disease or condition resulting in death) A 4005543 Medical Due to (or as a consequence of): **Examiner** Advanced dementia Sequentially list conditions, Examiner Due to for as a consequence of It any leading to immedia cause. Enter Underlying Cause (Disease or iinjury Infected decubitus ulcer **To the Hospital or Attending Physician:** The law requires that the death certificate be execut**e**c that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hypertension Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown History of alcohol abuse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
☐ Yes 2 🗓 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 14 Yes Other: 4X | Nursing Home 5 | Residence 6 | Other (Specify) 은 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year)

May 2009 27. Manner of Death Certificate: 28b. Time of 28c. Injury at I Director: After to 28d. Describe how injury occurred Fell at home Natural 5 Pending 1 ☐ Yes 2X No Unknown 2 X Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5012 8th Street, NE 4 Homicide determined Home within 24 hours a To the Funeral I Largo, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/9/2010 D0062116 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 7705 Belle Point Dr. Greenbelt, MD 20770 Meklit Workheh, State Registrar

10-02041 Christian Sinnott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cen	tificate of		id Wientan	,,	Z U	10 0943
Physicia Medical Exami		Decedent's Name (First, Middle, Last)     Christian Sinnott	_				2. Date of Death Month	Day Year	3. Time of Death 0815 hrs
neulcai Exaiiii	1161	4a. Facility Name (if not institution, give street a		4	b. City, Town, o	r Location of Deat	March 12,	2010 4c. County of I	
7		1840 W. Pratt Street			Baltimore				
Funeral Director		5. Social Security Number 6. Sex	7. Age (in yrs. la	st birthday)	If Under 1 Yes		0	F	9. Birthplace (State or or oreign Pennsylvan) Country)
Director		106-68-2478 13M 2	]F   36	Yrs.			01/18/	1974	Country) 1115 y 1 v 2111
any		10a. State 10b. County	10c. City,	Town or Location	n				10d. Inside City Limits
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hours 'natur		15. Decedent's Education (Specify only highe				ation (Give kind of e. DO NOT use re		16b. Kind of Busin	ness/industry
36 hin 72 e. than "	ompleted	Elementary/Secondary (0-12) Coll	ege (1-4 or 5+)	CDI V II	ruck Dr	ivor		Truck	ina
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "natu	S	17. Father's Name (First, Middle, Last)		CDIA I	TUCK DI		e (First, Middle, M		1119
2121 uld be fil Mental I marked	Be	Robert T. Sinnott, Ji					een Heis		<u> </u>
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she r traumatie event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationship (Type, Prinding M. Sinnott/Spot					Rural Route Numb		State, Zip Code)
imore, MD 2 Pages 1 and 2 shounent of Health and hands.		20a. Method of Disposition	20b. P	lace of Disposit	ion (Name of ce			20 / 13 20c. Location - Ci	ty or Town, State
MOFE Pages 1: nent of H ant: If it		Burial 2 X Cremation 3 Rem	ovar ironi otate	rematory or other tro Cre		03/	20/2010	Raltimo	re,Maryland
Baltimore, permit, Pages 1 at Department of Hee Important: If ite	1	21 na re Funeral S icensee	7		me and Addres	45 33	eall Fun		
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Physician /Medical		failure. List only one cause on each line.							Approximate Interval Between Onset and Death
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		Sequentially list conditions, b							
	nine	cause. Enter Underlying Cause	or as a consequence of)						
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Box 687 e death certifing the attending ed for use as t	Physician/	1 Vos 2 No 0 University	Unknown	1111 5 Othe	er (Specify)				
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tal Rec	5						1 <b>Y</b> Yes 2		Yes 2 No
Vital Reco ysician: The la his certificate ha	<u>ه</u>	25. Was case referred to medical examiner?	Inpatient 2 E	ER/Outpatient		Other Nursi		esidence 6 🗸	Other Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the finneral director, page 2 should the	٦ ا	1 ✓ Yes 2 No 27. Manner of Death 28a.		28b. Time of Inj		ry at Work?		w injury occurred	54161. 00010
ision Attendii r death. reetor: A	atio	Natural 5 Ponding		Fd 8:15	am 1	Yes 2 X No	unk		
ivision or Attence after death	ertification:	Suicide Suicide	. Place of Injury - At hor				28f. Location (St or Town, Sta	reet and Number of te) 1840 W	r Rural Route Number, City Pratt St
fospita t hours uneral	O	29a. Certifier	ecify) found in				Baltimo	re, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	edical	(Check only one)  2 Medical Examiner: On the land many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many and many an	pasis of examination an						
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RA		Therelow 111. K.	TR.	m. D.	O.C.	M.E.	GME	March 12, 20	10
0		30. Name and address of person who complete Theodore M. King, Jr., MD. As	cause of death (Item 2 sistant Medical Ex	•	11 Pann St	reet, Baltimor	e MD 21201		
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur				C, WID 2 1201		
Regist		MAR 2 2 2010	Denver 1	8. pa	K				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ MANUEL 5 MIECHOWSICI 10:20pmM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 801 Scenic Place 21032 Anne Arundel **Funeral** 5. Social Security Number 216–28–7953 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Z** M 2 □ F Months Country) 1²7²2⁴7 1⁹17 Director 92 Poland Usual Residence of Decedent 23a or 28a-f show should be filed within resistand Mental Hygiene.

7 is marked other than "natural", or items 23a or zou.

7 is marked other than "hadical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Anne Arundel Crownsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 801 Scenic Place 21032 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White Yes Give 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Body & Fender Repair Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Menta Important: If item 27 is marked, any injury or other trees. Joseph Smiechowski Jadwiga Loczycka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
801 Scenic Place Crownsville, MD 21032 Anna Lechowski Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Our Lady of the Fields 3/10/2010 Millersville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A, . Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conse uence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 2 🗌 No Yes 2 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) 2 No Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Division 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie WIS Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL My) ENTA

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAR 10

32. Rec

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 6 per FH G903 5/5/10 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death STERN Physician/ 乙. Month 3 VOI U PFORGE 023 UM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. 06/25/1955 **™** M 2-Director 212-68-6560 54 Washington, D.C Usual Residence of Decedent 28a-f show 10a. State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crofton 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1450 Harwell Ave. 21114 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 4 Driver FedEx Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Stern Marion Macko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Janice M. Stern/Spouse 1450 Harwell Ave., Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a 1 Burial 2 X Cremation 3 Removal from State 5 Other (Specify) 4 Donation 03/11/2010 Metro Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home <u>6512 NW Crain Hwy., Bowie, MD 20715</u> 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Small Onset and Death Physician/ Cu CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Year signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Completed Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? Yes 2 No page certificate 2 🗆 No 1 Tes Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 \( \text{Yes} \) 2 \( \text{No} \) ✓ Natural 5 Pending injury Accident M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner; the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 21438 ompleted ause of death (Item 23a) (Type, Print) Name and address of person who DEFENSE HIGHWAY ANNAPOUS MOLIYOF HAEL TAM 44T 7, TEN State 2010

Registrar

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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_		Registrar		Cer	tificate of D	eath	Re	g. No.		0 3 4 0 1
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Examin		4a. Facility Name (if not institution, give street and numi			4b. City, Town, or	Location of Death	march o.	4c. Count	v of Death	1 4.J/ A
		Anne Arundel Medical Cer	iter		Annapo	lis			ne Aru	ndel
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days		8. Date of Birth		9. Birthp	lace (State or Foreign
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within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practioner: To	of examination	and/or invest	igation, in my opinior	<ol> <li>death occurred at</li> </ol>	the time, date and	place and du	e to the caus	se(s) and manner stated
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10		30. Name and address of person who completed cause Stephen Killian, M.D. 3			,	)1 Edga	ater MD	21027		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 20 1°d MAC ARTHUR WELCH 8:01A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8160 HERON LANE LUSBY CALVERT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐M 2 ☐ F Months Days Min. Hours Yrs Director 64 220-42-1017 9-30-1945 MD. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinating that he notified at MD. 1 ☐ Yes 2√ No Director CALVERT LUSBY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8160 HERON LANE 20657 U.S.A. Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: \$ SpecifyWHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIP. OPERATOR SO.MD.CABLE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARCHIE THOMAS WELCH HAZEL LILLIAN WENK ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau DEANNA WELCH-SPOUSE 8160 HERON LANE LUSBY, MD. 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 3-23-2010_ALEX., VA. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M00479 RAYMOND FUNERAL Muli SERVICE, P.A. LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENDSTREE Physician disease or condition resulting in death) 40 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a contequence of) Examine requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a conse y ence of): O. Box 68760. physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregna ģ Month Day Year 5 ☐ Other (specify) ☐Yes 2 ☐No the 9 Unknown 9 Unknown þ σ. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas S autopsy page perform certificate 1 □Yes 2 No 1 ☐ Yes 2□No Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 5 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of ospital or Au.
24 hours after death.
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2 Accident 5 ☐ Pending investigation 1 □Yes 2 🗌 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one)

State

Registrar

DHMH 17 Rev 1/2001

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person who completed cause of death (Item 23a) (Type,)

29b. Signature and title of certifier

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For State Registrar			,	•		of Death			Reg. No. 2	110	ngi	36
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FORT WASH	IINGTON	HOSPITAL			FORT	WASHING	TON		PRING	CE GE	ORGES	
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10e. Street and Nur	mber				10f. Zip C	ode			10g. Citizen of	What Cou	ntry?	
P.O. BOX	415 /	3935 CHIC	AMUXEN	MARBUR	Y ROAD	20658	3		UNITED	STAT	ES	
11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.	Was Deceder	t of Hispanic C	Origin? (Sp	ecify Yes or No- Rican, etc.)	- 14. Ra		can Indian,	
1 Never Marri	ed 2 Marr	Armed Fo	2 <b>X</b> No		1 ☐ Yes 2	37		nican, etc.)	Bla	ick, White,	etc.	
3 DWidowed	4 Divorced	If Yes, G Year or E	ve Dates:		I∐Yes 2L	ANo Specif	y:		Speci	fy: BLA	CK	
(Spec	15. Deceden	t's Education st grade completed)		16a. Dece	edent's Usual (	Occupation done during more retired)	ost of work	ing	16b. Kind of E	Business/In	idustry	
12TH GRAI	ndary (0-12) <b>)E</b>	College (	1-4or 5+)		DO NOT use    SEWIFE	retired)			HOME	MAKER		
17. Father's Name	(First, Middle,	Last)				18. Mot	her's Name	e (First, Middle,	Maiden Surna	me)		
PHILLIP J	JOHNSON					CORA	ANN	SWANN J	JOHNSON			
19a. Informant's Na	ame/Relations	hip (Type. Print)		19b. Maili	ing Address (S	Street and Num	ber or Rur	al Route Numbe	er, City or Town	, State, Zij	p Code)	
PAUL M. W	VASHING	TON / HUS	BAND	P.O.	BOX 4	15 MAR	BURY,	MARYLA	AND 20	658		
20a. Method of Disp	position		201	. Place of Dispo cemetery, cre	osition (Name	of	-	Date	20c. Location	- City or To	own, State	
1 ☐ Burial 2 ☐ 4 ☐ Donation		3 ☐ Removal from pecify)	State	. CHARL	LES CEM	ETERY		18,2010	GLYMON	T, MA	RYLAND	
21. Signature of Fu	-	ON JOHNSON	M00583	-   Î	P. Name and HORNTO 1439 LI	Address of Fac N FUNER VINGSTO	AL HO	ME, P.A AD, IND	IAN HEAD	D, MA	RYLAND 2	20640
		complications that		eath. Do not en	iter the mode	of dying, such a	as cardiac	or respiratory ar	rrest,		Approximate Interval Betwe	
Immediate Cause (		CART	TAC AF	REST							Onset and Dea	atn

Month

1 Tyes

29d. Date signed (Month, Day, Year)

Day

2 **X**No

Year

**Physician** /Medical Examiner

Examiner burial-transit

Physician/Medical

þ

Completed

Be

Certification: To

Medical

29a. Certifier

29b. Signature and title of certifier

Director

Funeral

<u>Ş</u>

Be Completed

10

**Physician** 

/Medical

Examiner

**Funeral** 

Director

LYDIA 23a. Part 1. Enter shock, or he Immediate Cause disease or condition resulting in death) Due to (or as a consequence of): ATHEROSCLEROTIC HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify). 9 Unknown 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEPSIS SYNDROME 1 Yes 2 No 3 Probably 4 Unknown INFECTED SACRAL DECUBITUS ULCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 ANo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ XNo 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

attending physician I for use as the burial this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica the

D42955 2010 30. Name and address

EDGAR POTTER, M. D.

Pate filed (Month, Day, Year)

15 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 117Q1 LIVINGSTON ROAD, FORT WASHINGTON, MARYLAND

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** WILSO USSC 40 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** c. County of Death Four Seasons Hospice Baltimore Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug 30 9. Birthplace (State or Foreign Country)
Maryland **Funeral** Year) 924 Months Days Hours 1 X M 2 □ F 219-16-2095 85 **Director** Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 821 West St. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates 1 9 4 6 – 4 7 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Cab Driver Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis M. Wilson ပ Delena Malone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Wilson(Son) 2603 Lodge Farm Rd. Baltimore, Md. 21219 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Maryland Veteran 3 - 15 - 104 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. M.Mame Race of Seilin Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Examiner Physiclan: The law requires that the death certificate be executed Box 68760, P.O. Records, of Vital Division

death with the Maryland

Baltimore, Maryland 21215-0036

be filed within 72 hours after death with the Marylan ntal Hygiene.

9d other than "natural", or items 23a or 28a-f show event, its Medical Evantiner must be notified at

h and Mental Hygie

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othe any Injury or other trainment

**Physician** 

/Medical

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physician

attending p

ed by the signed be det

page 2 should

director,

has

certificate

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After

burial-

the

Hospital or Attending death. n 24 hours after death. e Funeral Director: A letely filled in by the fu Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 09438 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vernon Wharton Month 03 2010 0928 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Frostburg 4c. County of Death 328 Braddock Street **Allegany** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign County) **Funeral** 8. Date of Birth (Month, Day, Year) 11 30 1939 1 XM 2 F Months Days Hours Min 71 Director 216 38 1313 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits Director ₩ Yes 2 No Frostburg MD **Allegany** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21532 328 Braddock Street #213 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1

✓ Yes 2 □ No Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White If Yes, Give 1 Yes 2 No Specify: "natural", 3 Divorced Specify: Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Yard Master Railroad CSX Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I marked o Charles Wharton ပ Sylvia Lee Royer . Page 1 and 2 should iment of Health and N tant; If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 328 Braddock Street #213 Frostburg MD 21532 Susan Wharton (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 3/18/2010 Morgantown WV WVU Memorial Vault 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WVU Human Gift Registry Robert J. Bolyard per DVR O Box 9131 Morgantown WV 26506 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 5 years Physician/ disease or condition resulting in death) Metastic Pulmonary Carcinoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year n signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NIDDM Completed 1 X Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease 24a. Was an certificate has autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1🜊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0040095 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Pellegrino, 200 Glenn Street, Cumberland MD 21502 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 27 Registrar

DIS

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Day 20Î Edward Franklin Zimmerman 117 5:38 AΜ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov • 10, 1934 7. Age (In vrs. last hirthday) 9. Birthplace (State or Foreign Funeral Hours 1 📉 M 2 🗆 F Pennsylvania **Director** 220-30-9210 75 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1XXYes 2 No Maryland Washington Hagerstown ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral ll West Baltimore Street Apt. 209 21740 LISA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: 3 Widowed 4XXDivorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 10 Painter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Catherine Kindle Harry Benton Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Zimmerman, Sr.-Brother 433 West Church St. Hagerstown, MD 21740 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State cemetery, crematory or other place) injury Smithsburg Crematory 03-12-2010 Smithsburg, Maryland 4 Donation 5 Other (Spec 21. Signature of Funeral Servi 22. Name and Address of Facility Osborne Funeral Home, P.A. S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to ( Examiner monary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as a cunsequence of Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 - Ectopic pregnancy in the past 12 months? Pregnant at time of death Dav Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 🙀 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available 24a. Was an Jas autopsy performed Yes 2 X No prior to completion of cause of death? After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 🛣 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

05H-2

Registrar
DHMH 17 Rev 7/2009

State

1126 Opal Court

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khalid Waseem M.D.

2723

Hagerstown, MD 21742

03-11-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 2¹4 201 d Allen H. Ashby, III рм 1:34 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. 2/9/51 Country) 214-58-5567 Director 59 MD Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6132 Northwood Drive 21236 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married African American Maryland 21215-0036 Yes, 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) JHH-Sch. of Med. Sant. Engineer Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental I should be Allen H. Ashby, II Gloria Gardener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen H. Ashby, IV/Son Page 1 and 2 1344 Vida Way,Gwynn Oaks,MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō **=** 5 1 Burial 2 Cremation 3 Removal from State permit, Page Department of Important: If any injury or 3/26/10 #anover, MD Ardent Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. 21. Signature of Funeral Service Licens 22. Name and Address of FacilityHari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. nterval Between Immediate Cause (Final Onset and Death **Physician** disease or condition month Medical resulting in death) Examiner oholic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner attending physician and for use as the burial-transit executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 M Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔊 No Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De-th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending ☑ Natural 5 Pending Accident work? 1 ☐ Yes 2 ☐ No nours after death.

neral Director: Aft
dilled in by the fur Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5830 March 24 2010

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

57

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AANN J CHANGES W 6701 N ChanGe,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #9 State of Maryland Department of Health and Mental Hygerie /2010 JE 0 | 0 9 4 4 |

		1- For State Certificate of Deat	th .	Reg	j. No.	
Physiciar Medical Examin		1. Decedent's Name (First, Middle,Last)  Lewis Armstrong		2. Date of Death Month March 19, 2	Day Year	3. Time of Death 0832 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City,  3800 W. Belvedere Apt. 111  Baltir	Town, or Location of Death	-	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und	ler 1 Year If Under 24Hrs.	l l	(MM/DD/YYYY) 9. Birtl Foreigi	
Director	-	216-30-5470 1XM 2F 73 Yrs.		Mar 4,	1937 Cou	Maryland
ow any	Ī	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 X Yes 2 No
aryland Sa-f show at once.	Director	MD Baltimore  10e. Street and Number 10f. Zig	Code	100	g. Citizen of What Coun	71
h the Ma 3a or 2a		3800 W. Belvedere Avenue #1111	21215		USA	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho amatic event, the Medical Examiner must be notified at once.	Funeral		ent of Hispanic Origin? ( Sp ify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
s after c	ᇍ	3XX Widowed 4 Divorced If Yes, Give Year 1 Yes 2	No specify:  Occupation (Give kind of w	under donn HIII ki	opeony.	lack
72 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of wo	rking life. DO NOT use retir	red)	166. Kiria of Business/Ir	idustry GIIIC
5-0036 led within 72 Hygiene. other than '	등	unk 4 unk 0 Laborer  17. Father's Name (First, Middle, Last) - unk	18. Mother's Name	(First Middle M	aiden Surname)	unk
D 21215-0036 should be filed within 7 and Mental Hygiene. T is marked other than natic event, the Medica	a	George Armstrong	Clara	Moore	2	4010474-5
MD 2' d 2 should d 2 should lth and Ms n 27 is ms umatic er	٩	19a Informant's Name/Relatiopship (Type, Print) Herman White/nephew 711 N. Fr 111 Penn	s (Street and Number or B r <b>emont Ave</b> B n Street Balt	Rural Route Numb Baltimore imore, h	per, City or Town State, MD 2121 10 - 2120	Zip Code)
ore, lead of Healt If item		20a Method of Disposition 1 Removal from State 20b. Place of Disposition (Nan	me of cemetery,		20c. Location - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	ŀ	4 Donation 5 X Other Specify: in state Mt. Carmel Cer	m. 4/2	/2010	Baltimore.	MD North Ave.
Ba Dem Timp Timp	į.	Can Or Myly Baltin	nore. MD 212	15	· DOLLERINGTE	Fercut
Physician Medical		Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.  Atterpress legistic Cardiovascular Disease.	of dying, such as cardiac or	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):				5.1
	غِ	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	Examine	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):				1
		UNPENDED X AMENDED# 22 FTV COO2 / /7/2		_		
760, cate be ex physiciar the burial		#22perff, G902, 4///2 IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box 68760, e death certificate be the attending physic of for use as the buri		23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 5 Other (Spe		ncy	Month D	ay Year
BOy the death y the att	Physiciar	Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying		22a Did tak	acco use contribute to t	he serves of death?
P.O. res that the signed by be detack	출	rait in. Only significant conditions continuing to death but not resulting in the underlying	) cause given in Part I.		2 No 3 Prob	
ords, w requii	Completed			24a. Was ar autops	y prior to co	opsy findings available ompletion of cause of
tal Rec				perform 1 Yes 2		s 2 No
Vital ysician:		examiner?	26.Place of Death (Check of Donald Other) Nursing		tesidence 6 🗸 Other:	Scene
Division of Vital Records, P.O. rate of vital Records, P.O. and or Attending Physician: The law requires that the rate death.  The law requires that the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of the rate of t	-1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day, Year)	28c. Injury at Work?	28d. Describe ho	ow injury occurred	
/isior r Attenc ter death irector: n by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory			reet and Number or Rur	al Route Number, City
Division  Division  4 hospital or Attence  4 hours alter death  Funeral Director:  4 stely filled in by the	문  8 8 1	4 Homicide determined (Specify)		or Town, Sta		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as completely filled in by the funeral director, page 2 should be detached for use as	Medical	Check only  2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.				
F 3 F 8	ğ		c. License number		29d. Date signed (Mon	th, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		March 20, 2010	-
		Russell Alexander MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, Mi	D 21201		
Stat Registra						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 83aPt1,25 per me, g901,03/26/2010dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bellamy Eleanor 0.3 Medical 2010 3:15p. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchirst Hospice Baltimore Towson 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Months 1 M 2 XF Country) Director 71 216-36-0083 1 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Pikesville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Pamona Unit 21208 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 X Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City 2th grade Teacher 4yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph P. DeLeaver Sr. <u>Margaret E. Wiggins</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Marguerite Bellamy
20a. Method of Disposition Eugene Ave, Baltimore, Md 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge 3/25/10 Pikesville, Md 21 Signature of Funeral Service Licenses 22.Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Subdural hengtoma Medical resulting in death) Due to (or as a consequence of): Examiner Amyloid Angiopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 L. retai accu.

Pregnant at time of death
Unknown in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No I ∏ Yes of Vital 25. Was case referred to medical Be | 26. Place of Death (Check only one) examiner? Hospital: Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) HZSO After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R149194 Jul, CKNP March 17, 2010 28569 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Rit Towson, MD 6701 N. Charles. 21204 31. Date filed (Month, Day, Year) 62. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

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1 - State Amend Item 23aPt1,25 per me, g 067,03/26 pt Health and Mental Hygiene 19443 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Frederick Berghoff Medical March 4:30 p. Joseph 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll County General Hospital Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1 🔽 M 2 🗆 F Country) Maryland Director 940 216-36-2185 May Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dunda1k Baltimore Maryland 1 Yes 2 No 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? Completed by Funeral filed within 72 hours after death with 21222 United States 37 Yorkway 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: 'natural", Specify: 3 X Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) National Security College (1-4 or 5+) +4 Senior Executive of Health and Mental Hygie fitem 27 is marked other r other traumatic event, th Agency Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည pe Sophia M. Schaechtel Joseph S. Berghoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a Woodbine, Maryland 21797 17701 Huntmaster Court Karen L. Conn (Daughter) 3altimore, Department of He Important: If iten any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 3/23/2010 4 Donation 5 Other (Specify) Towson, Maryland Hilltop Service Corp. Signature of Funeral Service Licen 22. Name and Address of Facility Home of Dundalk, Inc. Dundalk, Maryland 21222 Duda-Ruck Funeral 7922 Wise Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Acute Myocarial Infarction Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Houre Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the bunal-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical CERTIFICATION Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HTPERTENSION Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page To the nospress.

within 24 hours after death.

To the Funeral Director: After this certificate h performed 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2N NO ဂ္ဂ 1 Inpatient 2 K ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending (Month, Day, Year) 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide М 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifier 5 29d. Date signed (Month, Day, Year) 1821231788 agto MID MARCH, 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMORE MD 2127-4 HAMID M. KARGRO 4940 31. Date filed (Month, Day, Year) 32. Registrar's Sig fature State MAR 26 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Amend Item 25	State of Maryland per me, g901,03	Department o 726/2010dhl Certificate	f Health and of Death	Mental Hyو ا	giene Reg. No. 20	10 09441
Physician /Medical	1. Decedent's Name (First, Middle, Last, Michael A. Brad	)			2. Date of Dea Month	ath	3. Time of Death 2 - 00 PM
	4a. Facility Name (If not institution, give	street and number)		n, or Location of Deat LTIMOR		4c. County of	Death
Funeral Director	370-44-0393	7. Age ( <i>In yr</i> s. <i>last</i> 7. Age ( <i>In yr</i> s. <i>last</i> 65	birthday) If Under 1 Ye  Yrs. Months Da			h Year) 1944 N	B. Birthplace (State or Foreign Country) Lichigan
ith the Maryland or 28a-f show ce rediffed at Director	Usual Residence of Decedent		own or Location				10d. Inside City Limits 1 □ Yes 2 ☒ No
th with the 23a or 2	10e. Street and Number 7331 Better Hours	court	10f. Zip Cod	21045		10g. Citizen of Wh USA	at Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Eventier must be routined at once.  To Be Completed by Funeral Director	11. Marital Status  1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent If Yes, specify C 1 □ Yes 2 🔯	of Hispanic Origin? (S Zuban, Mexican, Puer No <i>Specity:</i>	pecify Yes or No- o Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
21215-0036 ad within 72 hours att ygjene. ter than "natural", or t, the Medical Evenin Completed by F	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation 10 e completed) College (1-4or 5+)	6a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re salespe	ne during most of wor tired)	king	16b. Kind of Busi	ness/Industry
Maryland nd 2 should be file lith and Mental Hy 77 is marked oth retaumatic event	17. Father's Name (First, Middle, Last) Arthur Lewis Brace	iley			ne (First, Middle, et Helen	Maiden Surname) Daily	
and 2 sho ealth and n 27 is m	19a. Informant's Name/Relationship (Ty Elizabeth Bradle		9b. Mailing Address <i>(Str</i> 7331 Better	eet and Number or Ri Hours Co	ural Route Numbe urt Colu	er, City or Town, Si mbia, MD	tate, Zip Goda) 21045
Baltimore, bermit. Pages 1 an Department of Hea mportant: If Item 2 my Injury or other	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☑ Donation 5 ☐ Other (§ pecify)		of Disposition (Name of stery, crematory or other	place)	Date	20c. Location - Ci	ity or Town, State
Balt permit. Depart Import any Inj once.	21. Signa ure of Funeral Service Licens	Hade Pirector	State And Baltimore	dress of Facility atomy Boar e. MD 212		Baltimo	re Street
Physician /Medical	23a. Part 1. Enter the disease or comples of the comples of the comples of the comples of the comples of the comples of the comples of the comples of the comples of the comples of the complete of the comples of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complet	ne cause on each line.	o not enter the mode of	dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
execution and rial-trans	Sequentially list conditions, in the conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	Lation	CERTIFICATION	DROVED BY MEDIC	AL EXAMINER	10 days
	IF FEMALE:	i		CERTIFICATION			
P.O. Box 6 nat the death certification of by the attending etached for use as	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal dead 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐ Ectopic pregn 5 ☐ Other (specify			23d. Date Monti	
S, S, S, S, S, S, S, S, S, S, S, S, S, S	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying cause	given in Part I.			ute to the cause of death?  Probably 4  Unknown
_	Stroke					sy pri med? de:	ere autopsy findings available or to completion of cause of ath? ]Yes 2 ☐No
Phys rithis ral different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different different	25. Was case referred to medical examiner?  27. Manner of Death  12 Natural 5 Pending investigation	1 Panpatient 2 □ ER/ 28a. Date of Injury (Month, Day, Year) 28t	o. Time of lnjury 28c. I	Other		ne) lence 6  ☐Other low injury occurred	
Division  Division  Division  P Hospital or Attending 24 hours after death. P Funeral Director: After letely filled in by the fune	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)			City or Tow	n, State)	or Rural Route Number,
To the Hospir within 24 hours to the Funer completely fill		sician: To the best of my knowled ner: On the basis of examination and manner stated.					
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6	30. Name and address of person who co	mpleted cause of death (Item 23)	a) (Type, Print) WIEKEMS	AUT BU	lt mo	u MD	21229
State Registrar	NAR 26 2010	32. Registrar's Sonature	are				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5.000 M Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Center Aursin Kandallstaun Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 20-1130 Months Min (Month, Day, Y Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marylan 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral Dak items hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 ₩Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Store Manager and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Merke Wahlberg Page 1 and 2 should be Eliezer traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number) Department of Health as Important: If item 27 is any injury or other trau OOK Shadais 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State emetery, crematory or other a Cremator 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appr ximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ADATIC STYMOSI'S disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) Day Year by the be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ki80024 BISSASE. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed 2 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 \sqrt{Yes} 2 \sqrt{No} 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number Cent ROSES52

Registrar
DHMH 17 Rev 7/2009

State

2835 Smin Dumus #203 Boncoinous

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 1:50 William Hanford Brill March 2010 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hosptice of Chesapeake/Mandarin House Harwood Anne Arundel | Hours | Min. | Months | Days | Hours | Min. | Month | Day, Year, 04/18/1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 004-30-1019 76 Pennsvlvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore 1XYes 2 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 236 Prince George St. 21401 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give KOPCEIN Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Kon Year or Dates: War 1 ☐Yes 2 No Specify: ş Specify: White 3 Widowed 4 K Divorced Completed marked other than "natur 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Professor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar Brill Virginia Smith ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 1231 Palamino Drive, West Chester, PA Beth Brill/Neice Health em 27 i other Important: If item 2 any Injury or other ODCe. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services 103/29/2010 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licenses 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death uvothelial cancer Immediate Cause (Final **Physician** disease or condition resulting in death) a yeavs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any main, to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical certificate has been signed by the attending privector, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown Completed 1 Tes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident of thours after death.

Funeral Director: Afterely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestaate Rd. Annapolis, Md. selonich. MO

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2776 id AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Co. Chapel Hill Nursing Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 01/06/1936 W. Virginia Director 234-56-1841 74 Usual Residence of Decedent "natural", or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Baltimore Co. Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Robosson Road 21133 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates. Black injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Buffalo Tank Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mack Neal Burrell Nellie Mae Reynolds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Burrell(Brother) 616 Cheraton Rd., Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/05/10 Garrison Forest Baltimore, MD Signature of Funeral Service Licensee Joseph dr. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ere brovascu Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year Yes 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? Accident 2 🗆 No Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Medical

29a. Certifier

(Check only one)

MAR 29

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Hvenue

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** MARCH 5:10 AM ICTURIA 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death TOWSON RUXTON CARE BACTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 □ M 2**X □X** 212-01-4581 95 **Director** 11/15/1914 UNK Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show MD Baltimore Director Towson 1 ☐ Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21204 USA by Funeral 7001 N.Charles Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Marital Status UNK
1 □ Never Married 2 □ Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX0 Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) UNK UNK UNK HNK 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) outd be f permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev UNK ည UNK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard K. Abraham 305 Washington Ave. Suite 203, Towson, 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 **X** X remation 3 ☐ Removal from State Atlantic Crem. 3/23/10 Glen Burnie , MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2829 Hudson St. Skarda F.H. Baltimore, MD 21224 Skardu 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAGE NP DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and burial-trai Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 100 certificate 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1 | Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA : After thi 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours are: ____ To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical and manner stated. 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) 057722 MARCH 18 2010

Registrar

State

DHMH 17 Rev 1/2001

back

1838 GREENE TREE ROAD #300 PILESVILLE MP 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

LEONARD RICHARDSON M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month TYBURTUS BIRD 17517 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE JOHNS HOPKINS BAYVIEW MEDICH CENTRE If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 XM 2 Months Min. (Month Director 206 16 2547 83 July 10, 1926 Pennsylvania Usual Residence of Decedent Show 10b. County be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 7270 Bridgewood Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ★ Yes 2 No
If Yes, Give TATA Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Year or Dates. WW II Specify: White "natural", 3 🗌 Widowed 4 🗆 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Machinist 12 Brewery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Erma Rebuck Irvin Bird it. Page 1 and 2 shour. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Sproul Ct. Baltimore, Maryland 21220 Orlando F. Cellini III (Grandson) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State P permit. Page Department of Important: If any injury or Gardens Of Faith Cemetery 3/29/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex HOTIM Maryland 21221 23a. On 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) PHEUMONIA 5 days Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjuly by the attending physician and tached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signature should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed certificate 1 Yes 2 No After this certification funeral director, I Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Director; / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) And the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier € Certifying Physi⊏ian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) MARCH 25 2010

State Registrar

DHMH 17 Rev 7/2009

4940 EASTERN AVENUE, BALTIMORE, MD ZIZZY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR

32. Regis rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Vivian Bishop 2010 March 23 10:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Feb 25, 19 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country Unk **Funeral** 1 ☐ M 2 🖾 F 220-34-0733 71 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Washington Director Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 750 Dual Hwy 21740 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21K No Specify white 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Un (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Un iene. than " Elementary/Secondary (0-12) College (1-4or 5+) unk s 1 and 2 should be filed w f Health and Mental Hygier Item 27 is marked other th 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. Golden Living Center 750 Dual Hwy; Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☑Other (Specify) in state 21. Signature of Fundal Service Licensee Naylor State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic **Physician** ariwai 54 cars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician Physician/Medical the as 1 IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has autopsy certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation Year) 1 Yes 2 No within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital

P.O. Box 68760 Division or Vital Records,

> State Registrar

Medical

31. Date filed (Month, Day, Year)

ANZ PR

29b. Signature and title of certifier

29a. Certifier

(Check only

well treet Hagstonn 17 02/740 ) 368 HAF1. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D28365

3-24-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BURNAN Month 24 zo/0 PANCES T45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ATRIUM VILLAGE ASSISTED LIVING OWINGS MILLS Social Security Number g. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs 8. Date of Birth Birthpiac Country) MD Funeral 1 □ M 2 🕻 F Months Davs Hours 1272771916 Director 220-36-2048 93 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at lid be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 4730 ATRIUM COURT, #473 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Midowed 4 □ Divorced If Yes, Give "natural", Specify: Completed WHITE Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SIMON HERMON RAE ZINBERG , Page 1 and 2 should b Iment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBYN REMICK / GRANDDAUGHTER 8 HEATHCOTE, AVON, CT. 06001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or c 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 03/26/2010 REISTERSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD. PIKESVILLE. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death 258ASE Physician/ STRUCTUE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for se a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death 2 1 ☐ Yes 2 ☐ Unknown the a Hinknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURE TO THRIUS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 24 hours after death. Funeral Director: After this certificate h Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ALF ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

MAR 29 2010

TAMOND

POEEE52

SMITH NORMUE #203, BRITHORZ, HOLY PANSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10b & 10d, per FH G903 5/24/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year GERTRUDE 9:25 PM ALDWELL Murch 25 /Medical 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospital Baltimore Har bor 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/26/1919 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F 218-26-6600 90 MD **Director** Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. artment of Health and Mental Hygiene ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the M-dical Examiner must be notified at 10b. County N/A 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD 1 Yes 2 No Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3609 St. Victor's Street 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Be Completed by Specify Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Phone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Caldwell Marv Kina 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Stuber, Niece 211 Pine Street #607 Seattle, WA 98101 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 03/31/2010 Woodlawn Cemetery Baltimore, Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** meeks /Medical Due to (or as a consequence of) **Examiner** failure inknown Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Severe unknown Division or Vital Records, P.O. Box 68760, 外 Mayrupitra and burial-trar Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performe 2/ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗹 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) MBBS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 asw Hamac S. Hansner St. Baltimore 21275 Date filed (Month, Bay, Year) State Parke Registrar

3/21/10 Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per INF C902 4/05/2010. In State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayor 27,2090 RICHARD DONALD CUTRIGHT 5:53A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore 5. Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. Hours 233-34-1298 1XXM 2 - F March 199, 1924 West Virginia 86 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XX Yes 2 □ No Maryland Baltimore None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5815 Clearspring Road 21212 USA 12. Was Decedent Ever in U.S. Armed Forces?

No WWII If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 ☐ Yes XX No Specify: White Specify: 3XXWidowed 4 □ Divorced Year or Dates. any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Darius Lee Cutright Rebecca Olive Dooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 7361 315 Lorraine Drive Frederica, Delaware 19946 Trina N Freeman DTR 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Moreland Memorial Park March 30,2010 | Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) yce Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funeral 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due (or as a consequence of): reciproci Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of and -trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by left lea acute 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 Hospital or Attending Physician: The 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ittula Towsontown Blud 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State rank Registrar

DHMH 17 Flov 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Joseph E. Davenport 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 9. Birthplace (State or Foreign Country) Maryland n yrs. 80 If Under 1 Year If Under 24 Hrs 8. Date of Birth Knain To Physician DAYENPORT, Jaset **Funeral** 215-26-7498 1**X** M 2 □ F Hours S(Month, Day1Year) 1929 Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Dorchester MD Secretary 1 🗆 Yes 2 🛛 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21664 Funeral P.O. Box 236 Was Decede.
Armed Forces?
Yes 24 No -72 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Staff Sergeant U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Lewis 17. Father's Name (First, Middle, Last) ဨ Elwood Davenport 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $814\ 23rd\ St.\ Columbus,\ GA\ 31904$ 19a. Informant's Name/Relationship (Type, Print) Cheryl Cunningham-Step Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑Bµrial 2 ☐ Cremation 3 ٌ Removal√rom State competery, crematory or other place)
Mitchell National 04-01-2010 Ft. Mitchell, Alabama Ft. ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228 21. Signature of Funeral Service Licenses P v 1. Enter the disease, o omplications that cann d the de v. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. P 1. Enter the disease, Interval Between Onset and Death Immediate Cause (Final Physician/ ardiomyopa disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death cate has been signed by the a page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate Yes 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗆 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA MOSVICOS

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

egistrar's Signatu

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** AULA, M. DACHIS MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COLUMBIA HOWARD COUNTY GENERAL HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Sex 1 □ M 2 K F Months Days Hours 226-76-1694 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Marical Examiner must be refitted at ury or other traumatic event, Ite Marical Examiner must be refitted at 10c. City. Town or Location 10a. State 10h County Funeral Director HOWARD COLUMBIA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 11109 SWANSFIELD ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) FINANCIAL CONSULTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KATHLEEN AARON LYNN JOHNSON ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11109 SWANSFIELD ROAD, COLUMBIA, MD 21044 NEIL DACHIS/HUSBAND 20a. Method of Disposition
1 □ Burial 2 □ Cremation 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Pages Department of Important: If it any injury or or COLUMBIA MEMORIAL PK : 3/26/2010 COLUMBIA, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Necrotizing Physician Fasciitis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Septic Shock Sequentially list conditions Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Acute Renal and burial-tran

and any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): Morbid

4 ☐ Pregnant at time of death

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown 2 Be Completed

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24a. Was an

24b. Were autopsy findings available prior to completion of cause of

4: 15 PM

Birthplace (State or Foreign Country)

WHITE

ANDERSON

21208

Approximate
Interval Between
Onset and Death
48 howy

Year

ND

10d. Inside City Limits

1 □Yes 2 No

2010

USA

									perfo	ormed? 2⊠No	death? 1 ☐ Yes	2⊠No	
25. Was case referre	ed to medical						26. Place of Dea	eath (Ch	heck only	one)			
examiner? 1 ☐ Yes 2 🔀 N	lo	Hospital	: 1 ☑ Inpatient 2 □	ER/Outpatient	3 🗆 🗅	OOA	Other: 4 I Nursing F	Home	5 🗌 Resi	idence 6	Other (Spec	cify)	
27. Manner of Death 1 ⊠Natural 2 □ Accident	5 Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes 2 □ No	28d.	Describe	how injury	occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				er,
							the time, date and place						

00060345

5 Other (specify)

one)	,		Modical	
29b. Signature	and	title	of certifier	

and manner stated 29c. License number

29d. Date signed (Month, Day, Year)

MARCH, 24, 2010

Merrer Thurad 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite 310 Columbia M.D. 21044 10710 KAISER ALMIAD

State Registrar 31. Date filed (Month, Day, Year) MAR 29 2010

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

as

for use

: After this certific tuneral director, J

within 24 hours after death. To the Funeral Director: A filled in by

completely

Medical Certification: To

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	Physicia Medic		1. Decedent's Name (First, Middle, Le	ast) DWARDS	·					2. Date of D Month FeBe	Da			3. Time of Death	
-	Examir		4a. Facility Name (if not institution, giv	ŕ				-	Location of De		4c.	. County of D	eath		
1			5. Social Security Number 6.		e (In yrs. las		If Under 1		If Under 24 h		lieth	N/A	O:ethal	ace (State or Foreign	
	Funeral Director			1 DM OVE	0	Yrs.		Days			Day, Yea <i>r)</i> 13,19	29 M	Country) Maryland		
	and show	5	10a. State 10b. County		10c. City,	Town or Lo	cation						10	d. Inside City Limits	
	Aaryla 8a-f tified	Funeral Director	MD Balti	more o				E	dgemer	e				1 ☐ Yes 2X No	
	the last		10e. Street and Number				10f. Zip (	Code			10g. Cit	tizen of What	Count	y?	
	n with	nera	9110 Avenue	В			21	1219			Un	ited S	tat	es	
980	be filed within 72 hours after death with the Maryland antal Hyglene. Ked other than "natural", or items 23a or 28a-f show cevent, the Medical Examiner must be notified at	þ	Narital Status     Never Married 2 ☐ Married     Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 Y		1	Was Decede f Yes, specif 1 ☐ Yes 2	y Cubar	n, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)		14. Race - Al Black, W Specify:			
0	hours natur dical	lete	15. Decedent's	Education		16a, Deced	dent's Usual	Occupa	ition		16b. K	ind of Busine	ss Indi	ıstry	
21215-0036	led within 72 I Hygiene. other than " rent, the Mec	<b>Completed</b>	(Specify only highest of Elementary/Seconday (0-12)	College (1-4 or s	5+)	Ìife. D	kina of Work O NOT use r Dietic	retired)	uring most of	working				eterans on Hosp.	
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altimore,	e	3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		cer	netery, cren Lawn	osition (Name natory or oth Cemet	er place tery	-2	<b>25/2010</b> /15/2010	Ва		е,	Maryland	
Bal	permit. Pag Departmen' Important; any injury once,	1	21. Signature of Funeral Service Lice	nsee		22 D	2. Name and uda – Ri	Addres: uck	s of Facility Funera	1 Home o	f Dun	dalk,	Inc		
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-	Medical Examiner		disease or condition resulting in death)	a. Due to (or as	a conseque	nce of):	LAL		zmon	RHADE	1	/	T	2 0942	
	red	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a conseque	nce of):			J	MIL	ALEXAMINE	ER			
09	ite be executed hysician and the burial-transit		that initiated events resulting in death) Last	Due to (or as	a conseque	nce of):		Q	RTIFICATIONA	PPROVED BY MEDIC					
. Box 68760	le death certificate be the attending physici ched for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal o	death 3	Ectopic produced Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Cont		/			23d. Date of Month		y Day Year	
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a	iician: The certificate rector, pag	Be C	25. Was case referred to medical					26. Pla	ce of Death (C	Check only one)	2 2 3 110				
ξ	hysic nis ce I direc	၉	examiner? 1 Yes 2 No				nt 3 🗆 DOA	Othe	r: 4 🗌 Nursin	g Home 5 🗆 Res	sidence 6	Other (Sp	ecify)		
	Attending Physician: r death. ector: After this certific by the funeral director,	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not			8b. Time of injury	286 M	c. Injury work?		28d. Describe	how injury	y occurred			
Division	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,		4 Homicide determined		ury - At hom c. (Specify)	e, farm, stre	eet, factory,	office			(Street and own, State)		Rural F	oute Number,	
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1104 BM 26,2010 /Medical Name (If pqt institution, give street and number) 4b. City. Town, or Location/of Death 4c. County of Death Examiner e14 oup 10.1151 4050. 8. Date of Birth (Month, Day, Year) Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔂 Months Days Hours 264-34-1712 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Exar, it ar must be notified at Director 1 Tes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? ö 4650 2111 Alcor items 23a Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedon. _ Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No ģ Specify 3 ₩idowed 4 Divorced 'natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

NUTES HIGE m 27 is marked other than "retraumatic event" Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 140Mas 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alcott Way Johnson daughter Department of Health Important: If item 27 any injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) the detached been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performe 1 □ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) in 53 33 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 26,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 even 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per DVR g901 3/31/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** William Martin Eckard Month March 22 2010 7:20 A /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 177 Pennsylvania Avenue Westminster Carrol1 | Months | Days | Hours | Min. | April 14, 1 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 214-01-0574 1 X M 2 □ F 95 Director 1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar in ust be notified at MD Carroll Westminster Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 177 Pennsylvania Avenue 21157 by Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify: Specify: 3 Widowed 4 Divorced 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) wall paper & paint Elementary/Secondary (0-12) College (1-4or 5+) self employed store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Martin Eckard Catherine Dell ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James M. Eckard/son 18 Milton Ave; Westminster, Maryland 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Daniel A Naylor 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTERIOSCIEROTIC disease or condition resulting in death) HEBRI YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) o 1 ☐ Yes 2 ☐ No 9 Unknown þ ۵, signed k I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes DIARETES Completed MELLITUS peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 e DEMENTIA autopsy performed? page certificate of Vital 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 1663 3/23/10 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 447 EAST MAIN STREET 70 WESTMINSSTER and 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2010 MAR 29 Registrar

Amend 4c, per MD g902 4.13.10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mont 2010 **Physician** 14 12:50 A^M March Curtis Milton Eubanks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil Elkton

| Funder 1 Year | Funder 24 Hrs. | 8. Date of Birth (Month, Day, 1)
| March 5, Howard Elkton Care & Rehab 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 1⊠ M 2□ F 1934 76 **Director** 363-32-2672 Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at North East 1 ☐ Yes 2 No MD Cecil Director 10g. Citizen of What Country? 10f. Zip Code 21901 10e. Street and Number 23a or USA filed within 72 hours after death with 111 Old York Ct. Funeral 12. Was Decedent Ever in U.S. Aumed Forces? 1 ∰yes 2 □ No 1951— If Yes, Give Year or Dates: 1952 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 ö 1 ☐Yes 2X No Specify. <u>6</u> 3 ☐ Widowed 4 ₺ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any Injury or other traumatic event, Ine Media once. College (1-4or 5+) Elementary/Secondary (0-12) Chrysler Corporation electricial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ora Lee Smith Ancel Almond Eubanks 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 111 Old York Ct.; North East, Maryland 21901 David Eubanks/son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) State Anatomy Board; 655 W. Baltimore Street 21. Signature of Euleral Service Licensee Naylor Baltimore, Maryland 21201 Kim 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bother Charles Descen) COPD **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) sate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown DYSPHAGIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 2 2 No certificate 1 ☐ Yes 1 ☐ Yes ours after death.

neral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3/24/10 D0065733 P.V. Nough N MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELKTON, HD 21921 Smeet V. PULA NARMANA RAS 126 A E. HIGH 31. Date filed (Month, Day, Year) State MAR 29 2010 Registrar

Falieut known as Eleudin Moelen Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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Medic Examin		4a. Facility Name (if not institution, give si				Location of Death	·	4c. County		
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Funeral Director			7. Age (In yrs. la	St birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birthplace (State or For Country) MD	reign
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 / Medical Examin	cian: To the best of my knowler: On the basis of examination	n and/or invest	tigation, in my opinic	on, death occurred at	t the time, date a	nd place, and due	e to the cause(s) and manner	r stated.
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Ba	permit. Page Department Important: I any injury or once.		21. Significate of Funeral Service Lice	Polit	_	Name and Address	ASLUTON	F.H. P.A.	2134 W Bauti	Mars Social RA
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Division of Vital	within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director.	al Cert	4  Homicide determine	d 28e. Place of Injury - At building, etc. (Spec	cify)			City or Town		
1)	within 24 hours of To the Funeral Completed filled	Medical	(Check 2 L Medical Exa	nysician: To the best of my kno miner: On the basis of examinat urse Practioner: To the best of	tion and/or investi	gation, in my opinic	n. death occurred	at the time, date and	diplace and due to the	cause(s) and manner stated
	withi To th	5	29b. Signature and title of certifier	2	. ^	29c. License	number		9d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who	completed cause of death (It	em 23a) (Type, Pr		B160 Z		Marchi	9,2010
سنزر			31. Date filed (Month, Day, Year)	Stubbs :	302 Rei	ndolph	StD	enton, r	nd 2142	9
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Worth 6:50 PM OMAS (57//E 2010 20 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Riverview Nursing Home Essex Baltimore Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day Ye Days Months 212-26-7834 North Carolina Director 80 Yrs T929 Nov. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 28a-f 1 🗌 Yes 2 🖾 No MD Dunda1k Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2428 Plainfield Road 21222 United States items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? 14. Race - American Indian. Black, White, etc. P þ 1 Never Married 2 Married 1 Yes If Yes, Give 21215-0036 1 Yes XX No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Operator General Motors Corp. 8 Years Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Gilley Cora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2428 Plainfield Road Dundalk, Maryland 21222 Mrs. Marlene R. Gilley 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 Burial 2 X Cremation 3 Removal from State any injury or 3/23/2010 Important: Towson, Maryland 4 Donation 5 Other (Specify) Service Corp 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Dundalk. Mar-land Ave art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) signed by the a d be detached f g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician: The law requires been signated the Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate Yes 2 No Division of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 2 🗷 No မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 🗀 Pending injury work? 1 \(\sum \) Yes 2 🗌 No Accident Investigation Director d n by the 3 Suicide
4 Homicide de 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, after City or Town, State) within 24 hours aff To the Funeral Di completed filled in Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Zertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29b. Signature and title of

State Registrar 30. Name and address of payson who completed cause of death (Item 23a) (Type, Print)

IAMONA

31. Date filed (Month, Day, Year)

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10-02417 Carl Robert Grot Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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cal Examiner	4a Eacility Nam	ne /if not institutio	Carl n, give street and r		t Grot	h. 4b. City, Te	own, or L	ocation of I		March 26	<u> </u>	. County of Dea	ath	
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1215 be file antal H rrked vent, il		Paul C. Groth. Sr.  a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi									ate, Zip Coo	de)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		a. Informant's Name/Relationship (Type, Print) orothy Winterbottom(Sister)  651 Shore Drive Joppa, Maryland 21085												
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Function: After this certificate has been signed by the attending physiciately filled in by the funeral director, page 2 should be detached for use as the buriness filled in by the funeral director, page 2 should be detached for use as the buriness filled in by the funeral director.	IF FEMALE:	dent pregnant in	Alexan Francisco	es, outcome of prove birth	egnancy	Fetal death	3	Ectopic	pregnar	ncy	2	3d. Date of del Month	ivery Day	Year
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Division of Vital Records,  To the Hospital or Attending Physician: The law require within 24 hours after death.  To the Funeral Directors. After this certificate has been a completely filled in by the funeral director, page 2 should	4 Homi	cide de	termined (Spec	Single F								rove Road, D		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#19a, PERINF, G902, 4/2/2010, WS
State of Maryland, Department of Health and Mental Hygiene
Amend Item 25 per verb., g901,03/29/2010dnb/phys

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Month Charlotte T. Gallagher 03 20 2010 10:09A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 500 2814 Superior Ave. Baltimore Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | 10/17/1922 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 18 F 215-18-6053 MD Yrs. Director Usual Residence of Decedent Charollatte Gallagher 03/20/2018 Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County s 23a or 28a-f shows 1 ☐ Yes 2 No **Funeral Director** MD Baltimore Baltimore with the 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 2814 Superior Ave. 21234 USA 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes XNo 21215-0036 Specify: White Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Consumer Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Credit 12 treumatic svent, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mental H 7 is marked ott James Evan Hood Theresa C. Couturier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Importent: If Item 27 is
any Injury or other treu Bernard A. Gallagher, 2814 Superior Ave. Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 22, 1 ☐ Burial 2 ☐ Sremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mar. Chesapeake Crem. Beltsville, MD 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AFA/Stephen D.Lohrmann P.A. MO1585 Kelocca Hachermos 8717 Green Pastures Dr. Balto, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Suicide by asphykia.

Due to (or as a consequence of): Plastic bagover head Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No Division of Vital 1 ☐ Yes 2 🗷 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner: 1 Yes <del>2 X N</del>o Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Sucide by 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 28f. Location (Street and Number or Run | Route Number, City or Town, State) 2814 Superior Ave 1 ☐ Yes 2 🔀 No investigation March 20,2010 1009 A 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by 4 Homicide Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 29c. License number 018667 ou. Name, and address of person who completed cause of death (Item 20a) (Type, Print) Hill CT Lutherville, MD Trim ble 32. Registrar's signature 31. Date 6 Registra

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Michael E. Gom		1- For State Registrar	te of Marylar		artment of rtificate of		nd Ment			Reg. No.	20		09465
Physicia Medical Exami		1. Decedent's Name (First, Middle,	Last)	<del>ina</del> Mi	chael E	igene G	omerin	ıger	Month March 26	Day	Year )		3. Time of Death 0521 hrs
		4a. Facility Name (if not institution, Washington County Ho		ber)	4	b. City, Town, Hagerstov		f Death			c. County of <b>Nashing</b>		
Funeral Director			Sex 7	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Y	ear If Unde ays Hours		8. Date of E			9. Birth Foreign Cour	
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ith the Maryland 23a or 28a-f show notified at once.	Directo	10e. Street and Number  830 Dorsey Aven				10f. Zip Code				10g. Cit	izen of Wha	at Count	ry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho injury or other traumatic event, the Medical Examiner must be notified at once	by Funeral Director	11. Marital Status 1 X Never Married 2 Marr	12. Was Dece		If Y∈	Decedent of I	an, Mexican,				14. Race - White,	etc.	an Indian, Black,
136 hin 72 hours e. than "natur edical Exami	Completed t	15. Decedent's Education (Specific Elementary/Secondary (0-12)	y only highest grade College (1-4			st of working I					Kind of Bus		dustry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Con	17. Father's Name (First, Middle, La Joseph Jame	•	eringei		<u>Driver</u>	18.Mother		First, Middle	, Maiden	ruckir Sumame) Ernst	ng	
, MD 21 and 2 should lealth and Me tem 27 is ma traumatic ev	٩	19a. Informant's Name/Relationship  Timothy Gomerin  20a. Method of Disposition	(Type, Print)	ther)	19b. Mailing  830 F  Place of Disposi		Avenue	Es	ral Route No Sex N Date	/arv	•	2122	1
Baltimore, permit. Pages I an Department of Hei important: If ite		1 Burial 2 Tremation 4 Donation 5 Other Spec 21. Signature of Funeral Service Lie	cify:	ii State		emator	ss of Facility						Maryland
Physician	1 8	23a. Part I. Enter the disease, or co failure. List only one cause or	each line.		. Do not enter th	e mode of dyin	ig, such as ca	ardiac or i	espiratory a	rrest, sh	ock, or hea	rt -	and 21221 Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c			Leroti	c card	liova	scula	r di	sease		Destil
=	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c										
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X AMENDED 23a, P11, 2/, permE, g901 3/31/10 TT #1 as noted, per ME g901 3/29/10 TT T UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Live birth Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cirrhosis of liver 24a. Was an autopsy performed? ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 1 Yes 2 No 5 Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined

To the Hospital or Attending Physician: The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Other Nursing Home 5 Residence 6 Other within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 28d. Describe how injury occurred Medical Certificati 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one)

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 26, 2010 llein 30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

arka

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 🗸 Yes

Month

Year

31. Date filed (Month, Day, Year) State Registrar

Carol Allan, MD

32. Registrar's signature

Assistant Medical Examiner

			<b>pe or Print it</b> State of Maryl					Are Legible.	
	-	For State Registrar	State of Wary	•	tificate of			Reg. No. 2010	09466
		Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
Physicia /Medica		I homas A- (	Brahan	١			March	26, 2010	1326PM
Examine		4a. Facility Name (If not institution, give str			4b. City, Town, o	r Location of Dea	ath	4c. County of Deat	
		LACL			Baltin	ore If Under 24 Hr			
Funeral			/ 2□ F	yrs. last birthday) Yrs.	Months Days	Hours Mir	n. (Month, Da	ly, Year) Co	hplace (State or Foreign huntry) Columbia
Director		218-05-8617 Usual Residence of Decedent	89				5/28/	1920   Dis	trict of
ylanc how		10a. State 10b. County	10c.	. City, Town or Loc	cation				10d. Inside City Limits
e Ma	Director	Maryland Baltimore	E	ssex					1 ☐ Yes 2X No
ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
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ter de	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	. Was Decedent Ever in Armed Forces? 177Yes 2 □ No	n 0.5.	f Yes, specify Cub	an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	- 14. Race - Ame Black, White	
Urs at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1943 Year or Dates: 1945							hita
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M62 alth a salth a sar train		David Wayne Graham	(Son()	1539	William	s Avenue	Essex,	Marvland 2	1221
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Evantions.		20a. Method of Disposition	20	b. Place of Dispos		i	Date	20c. Location - City or	
imc. Page ment ant lury o		1 N Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)		acred He		1	3/30	Dundalk, Ma	rvland
Baft Dermit. Depart mport any inj		21. Signature of Funeral Service Licensee	1.4		. Name and Addre			·	
T	-	Michael C. Saffin Sr. Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221							
		23a. Part 1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line.  Approximate Interval Between Onset and Death							
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Chroni	L Ubs	trueti	re tul	monay.	Disease	
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7 4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or is a con	sequence of):	recour	COPULA	•		
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cords, P.O. Box 687 w requires that the death certificate the been signed by the attending physishould be detached for use as the	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pre	egnancy				23d. Date of de	livery
Geath death	cia	in the past 12 months?	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time		Ectopic pregnand Other (specify) _	су		Month	Day Year
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al Rec n: The law licate has r, page 2:							1 □ Yes	ormed? death? 2 No 1 ☐ Yes	2 □No
on of Vital duling Physician: th: After this certifical funeral director,	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 █ No	spital:	2   ER/Outpatien	ott	ner: V	eath (Check only o		
Phy Prhy er this	Ĕ	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inju	ry at		dence 6 Other (Spe how injury occurred	ecify)
3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office 28f. Location (									
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Hosp 24 hou Funei tely fil	edical	29a. Certifier  (Check only 2   Medical Examinar: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2   Medical Examinar: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
o the orthor or the orthor or the orthor	Med	29b. Signature and title of centric	and manner stated.	_	29c. Licens	se number		29d. Date signed (Moni	th, Day, Year)
E > E 2			1 //	MI		( all	11	2/2/17	0/1
		30. Name and address of person who com	pleted cause of death	(Item 23a) (Type,	Print)	7647		2/00/2	-010
-1	ļ	3900 hoch k	aven !	3000	Jard 1	Salta	vare t	(D) 217	(B)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature									
Registra		MAR 29 7	2010 Dines	in p.	17 Was				
DHMH 17 Rev 1/20	01								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 144 P M Hartzell 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Manyland Shock Traumo Balhmore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Aug. 29, 1 M 2 X F ^(ear)1930 Mary Tand Director 212-26-0557 Usual Residence of Decedent of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Carrol1 Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1799 Kats Dr. 21157 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 K Married Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Page 1 and 2 should be Robertson Mamie Jesse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Charles E. Hartzell (Husband) 1799 Kats Dr., Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Loudon Park Cemetery 3/26/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Liquid <u>3620 Wilkens Ave., Baltimore, MD 21229</u> 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Epidural Medical resulting in death) Due to (or as a consequence of) Examiner 7 days CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 🗍 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Arkery DISlase. 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes 2 LING Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examinet?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 ☐ Natural 2 ☑ Accident 5 Pending 0930 AM work? Fell in bathroom after death. Director: Af 03/14/10 Vanily Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

A.F. Nome 28f. Location (Street and Number or Rural Route Number completed filled in by determined Westminster 42 within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 03/21/2010 19807 30. Name and address of person who completed cause of death (Item 23a) (Type, Print S. Greene St Torres Bushmore

Registrar

32. Registrar's Si

Amend #21 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - State Amend #9 per FH g902 4/12/10 TCertificate of Death

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician tess aau March 26 255 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard County General Hospital olumbi Howar If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 11 (M94th 19341 Year) 1 □ M 2 🗙 F 68 181-34-3861 Director Pennsylvania Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show other than "natural", or items 23a or 28a-f showent, the Wedical Exeminational by notified at Director Pittsburgh 1 ☐ Yes 2 No Allegheny PA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15235 261 Garlow Drive USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No ģ Specify Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Education Instructional Aid 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be Helen Cole Otto A. Kirmeyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Pittsburgh, PA 15235 261 Garlow Drive Department of Health Important: If item 27 any injury or other tronce. John S. Hess - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 03-29-2010 Jefferson Borough, PA Jefferson Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licenses Leonard J. Ruck, Inc. Baltimore, Maryland 21214 Christina Hilton, per DVR Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and the control of the control of the cause of the control of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of th Immediate Cause (Final disease or condition resulting in death) MUDARY **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit por lang 1 51 Due to (or as a consequence of) Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. this certificate has been signed by the all director, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to edical examiner? eral Director; After this certific filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Man of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No death 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical сотріете and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) D0044763 Warch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4110-740-7777 Cedar Lane Columbia 146 21046 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		1 - State Registrar	State of Maryland	-	artment of F			leg. No. 0	0 09469
Physic /Med / Exami	cal	Decedent's Name (First, Middle, Last)     Aa. Facility Name (If not institution, give state)	Cora M.	H	augh 4b. City, Town, o	r Location of Death	Month March		
Funeral Director		212 20 323.		st birthday) Yrs.	Eastr If Under 1 Year Months Days		(Month, Day	y, Year)	timore 9. Birthplace <i>(State or Foreign</i> Country) Maryland
Maryland e-f ehow	ctor	Usual Residence of Decedent		Town or Lo	cation Dunda	ı1k			10d. Inside City Limits 1 ☐ Yes 2X No
th with the 23a or 28	Funeral Director	10e. Street and Number 7609 Gum Road			10f. Zip Code	21222		10g. Citizen of Wh United	
1215-0036 within 72 hours after death with the Maryland ene. than "neturel, or items 23a or 28e-f show than "neturel Exercites than the modified Exercites than the follips of the modified at the follips of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second energy of the second en	þ	11. Marital Status 1  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Amed Forces? 1		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
Iryland 21215-0036 should be filed within 72 hours after death with the Marylan of Menial Hygiene. marked other than "neturel", or items 23a or 28e-1 ehow matic event, it a Medical Examination matic event.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 Years	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Sing	durina most of wor	rking	16b. Kind of Busi Health Providi	Care
Maryland 2 td 2 should be filed the and Mental Hygie 27 is marked other treumatic event, in	To Be C	17. Father's Name (First, Middle, Last) Harry Rutherford						Maiden Sumame) rence Br	
Mary and 2 sho salth and 1 n 27 is mu		19a. Informant's Name/Relationship (Type Karen Yarbrough (	(Daughter)	203	ng Address (Street E. Ring	Factory			
Baltimore, Marylar permit. Pages 1 and 2 should by Oppartment of Health and Menta Important: If tiem 27 is marked eny injury or other treumatic enones.		20a. Method of Disposition  1 Burial ACCremation 3 Re  Donation 5 Other (Specify)			esition (Name of matory or other place Service (		Date 4/2010		ity or Town, State  Maryland
Balt permit. Departr Imports eny inje		21. Signature of Funeral Service License	e Colo	22	Name and Addre Duda-Ruck 7922 Wise	ss of Facility Funeral Ave. D	Home of undalk,	Dundalk Maryland	inc. 21222
Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting to death).					c or respiratory ar	rest,	Approximate Interval Between Onset and Death
/Medical		resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as a consequence to form as a consequence)	ence of):	CANCER				
3760, ate be executed hysician and he burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ence of):					
Box 68. death certific e attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	⊒Ectopic pregnanc; □ Other (specify) _	9		23d. Date Mont	of delivery th Day Year
Records, P.O. The law requires that the tate has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions con	tributing to death but not resul	lting in the u	nderlying cause giv	ven in Part I.			oute to the cause of death?  B Probably 4 Unknown
I Records, The law requires t	Completed							psy pri rmed? de	ere autopsy findings available for to completion of cause of eath?
of Vital F Physician: Th rthis certificate	o Be	25. Was case referred to medical examiner?	lospital:	2/2	Ott	105	ath (Check only o		
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Division tal or Attending ts after death. at Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, st	reet, factory, office		28f. Location (S City or Tox		r or Rural Route Number,
DIVIS To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by it	edical	29a. Certifier 12 Territying Physical (Crieck only only) 2 Medical Examin	diciane To the best of my knowner: On the basis of examinati and manner stated.	viadge; Jeal on and/or in	h occurred at the trivestigation, in my o	ne, date and place opinion, death occu	e, and dee to the urred at the time,	date and place, ar	and at stalled and due to the cause(s)
To t withi To t	Σ	29b. Signature/and title of certifier			29c. Licens	60320		29d. Date signed	(Month, Day, Year)
		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)	#20%	BALT	rimuris.	MD
S Regis	tate trar	31. Date filed (Month, Day, Year) NAR 2 9 2010	32. Registrar's Signati	par fra	the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 535 AM 26 2010 James Donald Hand 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) FRANKLIN Square Hospital Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number Days Hours Min. 12 M 2□F Months May 19. Maryland 217-74-0814 76 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Maryland Baltimore Rosedale 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 6706 Garvey Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Disabled 5 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leon S. Hand Marion Denton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) (cousin) Carolyn T. Gorsuch 6203 River Crescent Drive Annapolis, MD 21401 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Bunal 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 3-29-10 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part 1. Eller the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio rulmonal-Due to (or as a conseque ce of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itiated events resulting in death) Last HyperVpidomi Due to (or as a consequence 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□No 24a. Was an 1 □Yes

**Physician** /Medical Examiner

Important: If item 27 is any injury or other tra once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Directo

Funeral

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Completed

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Examiner

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Certification: To

Medical

Is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Experies must be notified at

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be innent of Health and Mental

permit. Pages 1 Department of H

Baltimore, Maryland 21215-0036

James

Hand

attending physiclan and for use es the burial-tran signed by the at d be detached for s certificate has t lirector, pege 2 s filled in by the funeral director

Hospital or Attending Physician: The law requires that the death certificate be executed

After this

after death.

within 24 hours a

completely

Division of Vital Records, P.O. Box 68760,

Completed by Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

25. Was case referred to medical examiner?

2 No 26. Place of Death (Check only one)

1☑Yes 2□No 27. Manner of Death 3 ☐ Accident 3 ☐ Suicide

4 ☐ Homicide

29a, Certifier

5 Pending investigation 6 ☐ Could not be

determined

1 Inpatient 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29c. License number D69540.

204

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Halham 6 5

Parkalle MD

State Registrar 10-02368

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

I nomas Harlow	_	1- For State Registrar		ate of Maryla		artment of rtificate of		nd Menta		Reg. No.	010	0947	
Physicia Medical Examir		Decedent's Nam	ne (First, Middl	e,Last) Thom <i>a</i>	a s	На	rlow		2. Date of De Month March 25	Day Ye	oor.	me of Death 009 hrs	
				n, give street and no	ımber)		b. City, Town, o	or Location of D		4c. County		<del></del>	
Funeral Director		5. Social Security I	Number - 3008	6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Ye		Adia	N/ irth(MM/DD/YYY . 10,195	Y) 9. Birthplac Foreign		
any	1	Usual Residence of 10a. State	f Decedent 10b. County		10c. City,	Town or Locati	on				10d.	Inside City Limits	
te Maryland or 28a-f show any lied at once.	5	MD		Baltimore	2				D	undalk	1 [	Yes 2 No	
e Mary or 28a-	Director	10e. Street and Nu 7825		gory Driv	7e		10f. Zip Code			10g. Citizen of W	hat Country?		
with th		11. Marital Status		12. Was Dec	cedent Ever in U.		Decedent of H		? ( Specify Yes or N		State: e-American In		
	by Funeral	3 Widowed		1 Yes  orced If Yes, Give Yes  or Dates:	2 X No		es, specify Cuba $_{ m Yes}$ 2 $\overline{ m X}$ N		uerto Rican, etc.)	White	te, etc. Whi	te	
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altir mit. Pa partmer portan		21. Signature of		Licensee /		22. N	ame and Addres	s of Facility	3/29/2010		son, Mar	·	
		Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222											
Physician /Medical Examiner		23a Part. Enter the disease, or complications that seused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive atheroscleortic cardiovascular disease or condition resulting in death)  Due to (or as a consequence of):											
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil.	Completed									osy prm <u>ed</u> ?		indings available tion of cause of	
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To the Hos within 24 h To the Fun completely	Medical (	29a. Certifier 1 (Check only one) 2		ysician: To the bes niner:On the basis of and manner s	of examination a							e(s)	
	Ĭ	29b. Signature and	title of certifier				29c. Licens			29d. Date sign March 25,	ed (Month, Da 2010	y, Year)	
	l	30. Name and addr		who completed caus			Baltimore	MD 21201		1			
Sta	te	31. Date filed (Mont	h, Day Year)	82. Re	gistrar's Signatu								
Registr		MAR	2920	11) Vener	w 1.	sparke							

Amenia Type or Printing Black Anderiby Indian Ensure All Copies Are Legible. Amend Item 25 tate of Mary 1900 1/039227 26 10 all Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 0/0 JUhr rederic /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner r Year I Under 70m 8. Date of Birth 06/23/19/2. Birthplace (State or Foreign (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Months Hours Min. Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples must be motified at HIMOR **Funeral Director** 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 XNo Specify Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last 18. Mother's Name (First Middle, Maiden Surname) Department of Health and Mental I Important: If Item 27 Is marked of any injury or other traumatic even ones ٩ Informant's Name/Relationship (Type. Print) (sister 19b. Mailing Address (Street and Number or Rural Ro ity or Pages 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Intra orania **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it say, and go transport cause. Enter Underlying Cause (Disease or injury that initiated events Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER we to for as a consequence of) The law requires that the death certificate be executed for use as the burial-trans and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the a 9 Unknown by signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' certificate 2 No 1 ☐ Yes Vital 1 ☐ Yes or Attending Physician; director. 25. Was case referred to medical examiner?
1 💆 Yes - 2 📆 No-Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 🗆 No s after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# IperPHYS, G902, 477/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
anna D. Jones 2 Date of Death 3. Time of Death Danna Physician/ Month MARCH Year 03:12AM <del>Denise</del> Dana Jones Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center TOWSOT Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. Month Day 0/16/ 1968 Director Maryland 213-82-0246 41 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6525 Brown Ave. Apt.20 21224 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. ð 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exa If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha unk Police Officer UMD at Baltimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ailroy Jones Evelyn Cambell permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6525 Brown Ave. Apt.2c, Baltimore, MD 21224 Leashia Jones(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Joseph Brown F/H And Crematory 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 04/01/10 Baltimore, MD Signature of Funeral Service Licensee Joseph Address of Facility on Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) METASTATIC BREAST CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy perform 2 No 2 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 Other: 2 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: / 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Number Practioner: (Check To the within 2 To the F orthy Smell 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Dav. Year) 12 D58944 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON. MARYLAND M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

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	_	1 - State Registrar					Cei	rtifica	te of	Deat	h		Reg.	No. 2	010	no	1471
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Funeral		5. Social Security Number	6. Sex		7. Age	(In yrs. la	ast birthday)	If Und	er 1 Year	If Und	er 24 Hrs.	8. Date o	f Birth		N/A 9. Birthr	lace (State	or Foreign
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LOIS OLYMPIA JONES MUTCH 2010 /Medical 4c. County of Death
BALTIMORE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7235 GOUGH STREET EASTWOOD 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 212-30-3469 1 □ M 2 💢 F Hours 76 **Director** 08/07/1933 MD. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director BALTIMORE EASTWOOD 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7235 GOUGH STREET 21224 UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married <u>م</u> 1 □Yes 2 No Specify WHITE Specify: "natural". 3 Widowed 4 Divorced Year or Dates Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6TH 0 MACHINE OPERATOR CANDY MAKING INDUSTRY other 7 is marked other traumatic event, . Pages 1 and 2 should be fill treent of Health and Mental H tant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE HAMER MARGARET MUELBERGER ౖ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR G. JONES, JR./HUSBAND 7235 GOUGH ST., BALTIMORE, MARYLAND other t : If item 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of important: if any injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) OAK LAWN CEMETERY 3/27/2010 BALTIMORE, MARYLAND Signature Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart billing. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** year a disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burlal-tran resulting in death) Last Due to (or as a consequence of) the attending physician ned for use as the burla Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 😿 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 re 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has t 24a. Was an autopsy performed? certificate 1 ☐Yes 2 No Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury death. investigation Hospital or Attend 24 hours after death Funeral Director: / 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number

State Registrar

Maryland 21215-0036

Baltimore,

Records,

Vital

ō

Division

70

DHMH 17 Rev 1/2001

940

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

32. Region

Mel

Matthew

31. Date filed (Month, Day, Year) MAR 2

29d. Date signed (Month, Day, Year)

March, 24, 2010

10-02172 Barry St. John

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rry St.	301111		State of Maryland / Departm  1-For State Certific  Registrar	cate of De		ientai my	-	g. No. 201	0 0947
	hysicia	an/	Decedent's Name (First, Middle,Last)	· -· · -· -· -· -· -· -· -· -· -· -· -·		T	Date of Deat     Month		3. Time of Death
edical	Exami	ner	Barry St. John	1			March 17,	2010	1415 hrs
•			Facility Name (if not institution, give street and number)     South Oldham Street		y, Town, or Loca timore	ition of Death		4s. County of Dea	th
Fu	neral		5. Social Security Number un 6. Sex 7. Age (In yrs. last bit	irthday) If U	nder 1 Year If	Under 24Hrs.	8. Date of Birt	h(MM/DD/YYYY) 9. B	irthplace (State orunk
Dir	ector		1区M 2 F 53	Yrs. Mo	nths Days F	Hours Min.	Dec 12	Fore	ign ountry)
	any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location					10d. Inside City Limits
**1	. ≥		MD Balti						1 X Yes 2 No
urylano	28a-f show d at once.	Director	10e. Street and Number	10f.	Zip Code		10	og. Citizen of What Co	
the M	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		617 S. Oldham St.		21224			USA	
th with	tems 2 st be n	Funeral	11. Marital Status UNK 12. Was Decedent Ever in U.S.  Never Married 2 Married Armed Forces? unk		edent of Hispanio			- 14. Race - Ame White, etc.	rican Indian, Black,
ter de	", or i		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes	2X No spe	ecify:		Specify: Wh	ite
ours at	atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a.					16b. Kind of Business	
16 n 72 h	dental Hygiene. narked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	duning most of	vorking life. DO	NOT use retire	ed)		
-00.3 withi	giene.	E O	unk unk unk  17. Father's Name (First, Middle, Last) unk		18 M	other's Name	(Eirst Middle M	Maiden Sumame) UN	k
<b>21215-0036</b> uld be filed within 7	ked of	Be C	The duty of tame (113), Middle, Eddy delle		10.140	other s realine	(First, Middle, M	naideir Surrame)	
21 nould t	is mar	10						ber, City or Town, Stat	
MD nd 2 sh	alth an							Maryland 2	
Baltimore,	nt of Health and N t: If item 27 is n other traumatic			of Disposition (I atory or other pla		у,	Date	20c. Location - City o	r Town, State
Itim it. Pag	rtment ortant:		4 Donation 5 X Other Specify: in State  21. Signature of Funeral Service Licensee/	22 Name a	nd Address of E-	acility			<del></del>
Ba med	Departi Importi		// Daniel A. Naylor					W. Baltimo	re Street
	ician		23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.	not enter the mod	e of dying, such	as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
	dical niner		Immediate Cause (Final disease a. Atherosclerotic Cardiovascu	ular Disease					Death
			or condition resulting in death)  Due to (or as a consequence of):						
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<b>876</b>	e attending phy for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy	y 2 Fetal dea	th 3 Ec	ctopic pregnar	псу	23d. Date of delive Month	ry Day Year
ox 6	attend or use	Physician/N	Program at time of death	5 Other (S	pecify)				
. B	by the	Phy	Part II. Other significant conditions contributing to death but not resulting	ng in the underly	ng cause given i	in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
Records, P.O. Box 68760, The law requires that the death certificate be executed	signed I be det	d by	Chronic Alcohol Abuse				1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
of Vital Records, og Physician: The law requir	s been should	Completed					24a. Was a autops		utopsy findings available completion of cause of
ecc The lav	ate ha	mo				-	perform	med? death?	Artes Art area
Ea .	certificate ector, page	Be	25. Was case referred to medical examiner?		26.Place of De		nly one)		
Flysic Si	this I dir	2	1 Yes 2 No Rospital 1 Inpatient 2 ER/C	Outpatient 3	DOA Other	, Laronia		Residence 6 🗸 Othe	er: Scene
Sion of Vital I	th. : After e funera	ion:	27. Manner of Death  1 V Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b.	. Time of Injury	28c. Injury at V		28d. Describe h	ow injury occurred	
Division	irector n by th	ertification	2 Accident Investigation 28e Place of Injury - At home f	farm, street, facto	ry, office buildin	ig, etc.	28f. Location (S	treet and Number or R	ural Route Number, City
. <u>e</u> .	hours after neral Dire / filled in b	Certi	4 Homicide determined (Specify)				or Town, St	ate)	
ne Hos	within 24 h To the Fun completely	cal (	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, de						
Tot	To t	Medical	2 Medical Examiner: On the basis of examination and/or and manner stated.		my opinion, deat		the time, date a	29d. Date signed (Mo	
			/ Va. L. R. W.	ľ	O.C.M.E.			March 18, 2010	wwy, roury
			3 Name and address of person who completed cause of death (Item 23a)						
				1 Penn Stre	et, Baltimore	, MD 2120	01		
	St Regist	ate	31. Date filed (Month, Day, Year)  NAR 2.9 2010  32. Registrar's Ignature	ukal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 23. Ola H. Kiefer 9:41 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie Anne Arundel Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Days Hours Min. **Director** 219-01-2333 Maryland 91 Nov. Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Start: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Catonsville 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29 E Montrose Manor Court 21228 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sallie Garland Clarence J. Conway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 2 Dutton Avenue; Catonsville, MD 21228 Craig Hornig Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3/26/2010 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 . Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or convolications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by LIVER METASTASES 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown LUNG METASTASES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 XNo Other: 1  $\square$  Yes ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5  $\square$  Pending 24 hours after death Funeral Director: A 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis or examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and 5 10755 FAUS RD, SUITE 200 LUTHERVI death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ March 27. MARY LINTZERIS 2010 12:26A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 M 2 XXF Days Hours Min. Audionth 2 an 1998 189-10-5897 91 Director Pennsylvania Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f show all providents in the Madical Examiner must be notified at an injury or other traumatic event, the Madical Examiner must be notified at 10a. State 10h County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXNo Maryland Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21842 USA 11500 Coastal Highway 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 AM No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: 3 XXWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disability Examiner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Stamatakos Sophia Vergeris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3543 Newland Avenue Baltimore, Maryland 21218 George Demetrios Lintzeris 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Greek Orthodox Cemetery XX Burial 2 Cremation 3 Removal from State Mar.30,2010 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Pervice Lic 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ MOMODIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail doc.
Pregnant at time of death in the past 12 months?
1 Yes 2 No Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ibans thrombocytopenio 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes Phospital or Attending Physician: 24 hours after death. Funeral Director: After this certific leted filled in by the funeral director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 Alo Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatura and title of certifie 29c. License number

State Registrar 30. Thame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Yea 23AM Vincent Gordon Lanasa MAR 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SPITA TIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 14, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Maryland 217-24-5411 80 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Examine rings to institute at 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 3300 Benson Avenue Apt 306 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 3 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐XNo \$ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Distribution Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Lanasa Beulah Lowman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 3300 Benson Avenue, Apt 306; Baltimore, MD 21227 Marguerite Lanasa Pages 1. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State Department of Important: If It any Injury or c 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 3/29/2010 Atlantic Crematory Glen Burnie, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Synature of Funeral Service 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SCHEMZC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last law requires that the death certificate be exect Due to (or as a consequence of): Physician/Medical as IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No for Month Year Day 5 Other (specify) the Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Ś Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 🗆 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes 2 No Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28d. Describe how injury occurred Division or Attending i Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 No within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
21 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number

State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Sm

32. Fegistrar's Signature

#AS24385284349

900 (ATON AVENUE BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SARAH LANDER Physician/ MARCH 25 Day 2010 ar 12:35P M Medical 4a. Facility Name (If not institution, give street and number)
GILCHRIST HOSPICE CARE Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON 087-07-2790 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours Country) POLAND 0472871915 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I firem 27 is anarked other than "natural", or items 23a or 28a-f sho important: If item 27 is anarked other than "natural", or items 25a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PARKVILLE MD BALTIMORE 1 ☐ Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21234 8810 WALTHER BLVD., #220 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces ò Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKÉR OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DAVID KAMERMAN ROSE RIES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 FOX CHAPEL DRIVE TIMONIUM, MD 21093 SUSAN SCHECHMAN / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗀 Cremation 3 🙀 Removal from State BETH ABRAHAM CEM. 03/25/2010 E.BRUNSWICK, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Melanoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iliquity that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law "equires hin 24 hours after death. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? 2 🔲 No ☐ Yes 2 [ 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Other: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28c. Injury at work? 1 ☐ Yes 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending 2 | No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral I 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier D64395 MARCH 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21204 DANIEUE OBBETMAN, MO 6701 NCHAPLES ST. SUITE 4105

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

		-	1 - State of Maryland / L State Amend Items 23artII,25 per me	Certificate of	5/2010and Death	Mental Hyg	iene	20101					
			1. Decedent's Name (First, Middle, Last)  2. Date of Death										
	Physicia Medic		Grace Morgan			March	$17^{9}$ $2010$	9:59 PM					
	Examin		4a. Facility Name (if not institution, give street and number)		or Location of Death		4c. County of Deat	h					
<b>1</b>	<i>-</i>		2512 Washington Blvd.		altimore	T	N/A						
L	Funeral Director		5. Social Security Number  6. Sex 1 □ M 2 ▼ F  7. Age (In yrs. last birth 72  Usual Residence of Decedent	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day March 3		thplace (State or Foreign ryland					
	Maryland :8a-f show tified at	Director	10a. State 10b. County 10c. City, Town N/A	or Location Balti	more			10d. Inside City Limits					
	with the I s 23a or 2 ust be no	Funeral Di	10e. Street and Number 1504 DeSoto Road	10f. Zip Code	21230		10g. Citizen of What Co United Sta	-					
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☑ No  If Yes, Give  Year or Dates.	13. Was Decedent of If Yes, specify Cub	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.					
215-0	in 72 hou e. nan "natu e Medical	Completed by	15. Cecedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)	Decedent's Usual Occu (Give kind of work done life, DO NOT use retired	during most of work	of working 16b. Kind of Business Industry							
7	ygien ygien her th	Be C	10	Homemaker	T		Own Home						
and	be file ental H ked of c ever	To B	17. Father's Name (First, Middle, Last) Richard B. Martin		18. Mother's Nam		Maiden Surname) Rittmeyer						
Maryland 21215-0036	2 should Ith and Me 27 is mar		19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Stree 512 Washing	t and Number or Run	al Route Number,	City or Town, State, Zij	o Code) 230					
Baltimore,	age 1 and ent of Hea nt: If item y or other		1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Wester	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Westerlett FrameRes 1 other place) Crematory  3-19-									
Balti	permit. P Departm Importal any injul		21. Signature Furieral Service Licensee	Odenton, M eral Home, rbutus, MD	Inc.								
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.										
	Pnysician/ Medical	3	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										
محمريب	Examiner	er	Sequentially list conditions.			11/	/						
Ī	outed nd ransit	Examiner	if any, leading to immediate cause. Extra Underly 5 Cause (Disease or linjury that initiated events c.	ot):	MAP	WEDICAL EXAM	INER						
200	te be exec ysician a ne burial-t	ledical E	resulting in death) Last  Due to (or as a consequence of d.	of):	TIFICATION NO PROVED								
687	irtifica ling ph e as th		IF FEMALE:										
. Box (	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3  Ectopic pregnar 5  Other (specify)	ncy		23d. Date of de Month	livery Day Year					
Division of Vital Records, P.O. Box	luires that t in signed b uld be deta	ed by P	Part II. Other significant conditions contributing to death but not resulting in the pertension	in the underlying cause o	iven in Part I.		bacco use contribute to	the cause of death?					
3ecor	he law rec te has bee age 2 sho	omplet	Spinal Cord Compres Breast Cancer with Metastases	Sion due	to	24a. Was a autop:	sy prior to death?	topsy findings available completion of cause of					
ā	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?  1		Place of Death (Chec								
<u> </u>	Physion this call direct	To To	TE inpatient 2 E El voc	itpatient 3 DOA Ot			since of the Other Oper	Daughter's Home					
o uc	nding ath. : After e fune	icate		njury wo		28d. Describe no	w injury occurred						
Division	al or Atters after dezente la Director de in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,					
	e Hospita 24 hours e Funera bleted fille	Medical	29a. Certifier (Check (Check only one)  1	or investigation, in my opin	ion, death occurred a	t the time, date an	d place, and due to the	cause(s) and manner stated					
_	Vithi Vithi Comp		29b. Signature and title of certifier	29c. Licen			29d. Date signed (Mont						
			> led parmen, mo		1) 153		3-18:0	3010					
			30. Name and address of person who completed cause of death (Item 23a) (  K. S. Dhar mase na M. D.  31. Date filed (Month, Day, Year)  32. Registrar's Synature  AR 29 2010	Type, Print)	Otec Si	. Ba	1timor.	skelf am					
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Synature	artel									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:30 YAKCH Medical 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death Examiner 4c. County of Death 4AKFORD 4VGNUE KIUGRdal If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Birthplace Country) Ohio **Funeral** Months Days Hours Min. 41 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liquy or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Riverdale 1 Yes 2 K No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6516 Auburn Avenue 20737 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 K Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Information Technology Web Programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kenneth McCray Doris Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Langill/Partner 6516 Auburn Avenue, Riverdale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation Services 03/29/2010 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fineral Service Lense 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Pnysician/ Medical Examiner Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760

page 2 should within 24 hours after de To the Funeral Directo completed filled in by th

Completed by

Be ျ

Certificate:

Medical

LUIS

DIAZ

29 2010

31. Date filed (Month, Day, Year,

Immediate Cause (Final disease or condition resulting in death)	a. COLON CANER  Due to (or as a consequence of):		Onset and Death 2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	1  Yes  24a. Was an autopsy performed?	
25. Was case referred to medical	26. Place of Death (Check	1 Yes 2	No 1 Yes 2 No
examiner? 1  Yes 2 No	Hospital: Other:		6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Year) Injury work?  n M 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred
3 Suicide 6 Could not be 4 Homicide determined		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death occurred at the time, date and place, and	d due to the cause(s)	and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0057984

BALTIMORE,

29d. Date signed (Month. Day, Year)

MD

2010

21287

State

Registrar

ORLEANS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1650

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year MARVIN MARCH 22 2010 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 8184 Del Haven Road Baltimore Dunda1k 8. Date of Birth (Month, Day, Year)
Dec. 30,1922 If Under 1 Year | if Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2√□ F Yrs Maryland 219-16-4305 87 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No **Baltimore** MD Dunda1k 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21222 8184 Del Haven Road 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes X ☐ No Specify: Specify: White 3 Widowed 4 Divorced

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Steel Industry

Dundalk, MD

Month

29d. Date signed (Month, Day, Year)

Approximate Interval Between Onset and Death

WEEK

3 MONTH

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2010

Funeral Completed Be

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Elementary/Secondary (0-12)

Director

death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed and as the burial-tran physician been signed by the attending should be detached for use as cate has I page 2 s or Attending Physician: after death.

| Director: After this certification by the funeral director. within 24 hours aft

To the Funeral Di

completely filled in

Steel Worker 6 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hallie D. Spurier ည Arthur E. Crouse, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8184 Del Haven Road Dundalk, Maryland Stacy R. Zeller (Granddaughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Ht. of Jesus Cem.3/27/2010 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Unda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): OSTEOM EUTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine STROKE Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Medical Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State Registrar

29a. Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
MAR 29 2010

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JENNIFER HAYASHI 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD 21224

冠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D62032

Amend #26 per MD Gyol 3/29/16 Flack Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 🚄 🖰 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 24, March 2010 8:25 AM Albert Carl Melaragno /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4016 Arjay Circle Ellicott City Howard 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 X M 2 □ F Hours Country 1922 Director 87 286-18-9230 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location th and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercites must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1152 Newfield Road 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. White \$ 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bartender Restaurant permit. Pages 1 and 2 should be filet.
Department of Health and Mental Hyg
Important: If item 27 is marked other
any Injury or other traum..... Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joe A. Melaragno Maria Apollonio ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1152 Newfield Road; Baltimore, MD 21207 Stella Melaragno Wife 20a. Method of Disposition 20c. Location - City or Town, State Date Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD Lake View Mem. Park 3/27/2010 Sykesv

22. Name and Address of Facility Sterling Ashton
Funeral Home of Catonsville, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Ashton Schwab Witzke 21. Signature of Tymeral Service Lipen 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to ( as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed sician and burial-trans Due to (or as a consecute P.O. Box 68760, the attending physician hed for use as the buria! Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 【 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Daughter's Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Other (Specify) After this Residence funeral Hospital or Attending Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting Plasting 27. Manner of Death 28a. Date of Injury 28b Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 Accident 2 🗌 No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral I 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner-stated. 29b. Signature and 29c. License numbe person who completed cause of death (Item 23a) (Type, Print) 30. Name and add MD 40 31. Date filed (Month 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death -3010 Year **Physician** 9:50AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 420 Nelson venue If Under 1 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) ocial Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1**2** M 2□ F Months Days Hours Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 1 Yes 2 No Director imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Velson USA 212-15 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21275-0036 1 ☐ Yes 2 ☑ No ģ If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced 3/ac Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (9-12) College (1-4or 5+) dising 18. Mother's Na (First, Middle, Maiden Surnan 17. Father's Name (First, Middle, Last) Be ٩ Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City n, State, Zip Code) Mi) 21215 Mmore PRUC 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Balto. mD 24-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses C. Greene Funeral Services Vaushn C. Greene Funeral Services Road, Randallstown MD01/33 bei 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 1 tarens U /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, long cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 2 X No 1 ☐ Yes 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 ☐Yes 2 ☐ No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1D Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 D 0 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) tue, Baltmar D 6

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 29

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep	eartment of Health and Nertificate of Death	2010	09486
		Registrar  1. Decedent's Name (First, Middle, Last)	Timeate of Beatif	Rag. No.  2. Date of Death	3. Time of Death
Physi	ician	- Maril		Month Day Ye	2:05 am
/Med Exam	dical	Fdith Blanche Man Lo  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		
Exam	imer	Riverview Care Center	Essex	Baltim	ore
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			Birthplace (State or Foreign Country)
Directo		219-03-0919 1□M 2∏F 90 Yrs.		6/22/1919 M	aryland
p .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or t	Location		10d. Inside City Limits
sho	2				1 ☐ Yes 2 1 No
the N	Funeral Director	Maryland Baltimore Essex	10f. Zip Code	10g. Citizen of Wha	at Country?
with the or	ā	no a simil pard	21221	U. S. A.	
leath ms 23	Pera	29 Cardinal Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- 14. Race -	American Indian, White, etc.
after o			1 ☐ Yes 2 ☑ No Specify:	Specify:	
2 12 15-UU30  I within 72 hours after death with the Maryland jiene. Than "natural; or Items 23s or 28s-f show It a Maryle Examine must be redified at	29	3		16b. Kind of Busin	White
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within ene.	patainmo	Elementary/Secondary (0-12) College (1-4or 5+)	,	Social	Security
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6 0 C -		20b. Place of Dis	position (Name of rematory or other place)	Date 20c. Location - Ci	ity or Town, State
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Baltimo permit. Page Department ( Important: If any injury or	g	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bruzdzinski Funera 1407 Old Eastern	al Home PA	1 21 221
<b>n</b> && E &	a	Michael C. Jaffin, Sr.	1407 Old Eastern A	Avenue Essex, Ma	ryland 21221
		23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	A A A A A A A A A A A A A A A A A A A	c or respiratory arross,	Interval Between
Pnysicia		Immediate Cause (Final disease or condition resulting in death)	Allugan	Dis core	2-5MG
/Medic Examin	_	Due to (or as a consequence of):	Antonio	Disorre	cur known
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vision of Vital Records, P.O. Box 68760,  Attending Physician: The law requires that the death certificate be executed reash.  The control of the certificate has been signed by the attending physician and by the funear director name 2 should be detached for use as the burst-transit		d			
68 ntifica ng ph		IF FEMALE:			4.45
Box 68 leath certifica attending ph		23b. Was decedent pregnant in the past 12 mgnths?	3 □Ectopic pregnancy	23d. Date Mont	of delivery h Day Year
O. E e dea the at		IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown	5 Other (specify)		
P.O. BOX that the death cer ed by the attendir detached for use			e underlying cause given in Part I.	23e. Did tobacco use contril	oute to the cause of death?
cords, P w requires that been signed to should be deta	3	Severe Osteobosoris, r	lan- beeling	1 ☐ Yes 2 ☐ No	Probably 4 Unknown
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Rec ne lav	1	Severe Osteoposoris, n fectures Anone, Chro	7.0(1.	performed? de	eath?
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Division of Vital Records, at or Attending Physician: The law requires tatler death.  Director: After this certificate has been significate that the fundard director page 2 should be.	Ś.	27. Mannager Death    A   Watural	, street, factory, office	28f. Location (Street and Number City or Town, State)	r or nural noute rumber,
Dital cours af urs af Derail Disability	Delic I		eath occurred at the time, date and pla	ce, and due to the cause(s) and mar	nner as stated.
Division of Vital Re  To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha	stery r	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, do and manner stated.	or investigation, in my opinion, death oc	curred at the time, date and place, a	nd due to the cause(s)
o the other	adus.	29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
		Mt M.D.	12-387	454 03-	27-2010
	İ	30. Name and address of person who completed cause of death (Item 23a) (Ty	/pe, Print)	110 110	21771
		MALIKA DASBEM. +09	CASIERN	LV D. IVI.D	(
1 14 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Stat	MAD O O OOLO NO MALLO CO	parket		
20/	gistra	MAK Z Y ZUIU KANAN	11		

DHMH 17 Rev 1/2001

10-02024 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Wallace McMillan State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day March 11, 2010 Month 1127 hrs Medical Examiner William Wallace McMillan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Linthicum 7000 Elm Road Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. Country Kentucky Director May 21, 1963 587-15-7970 46 1 X M 2 F Yrs Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Elkton Elkridge 1 Yes 2 No or 28a-f show MD Howard or items 23a or 28a-f shormust be notified at once. more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 5938 Montgomery Road USA Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married 1 Never Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: the Medical Examiner Specify: white þ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry ted o during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet other than education professor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) ment of Health and Mental rate in trant: If item 27 is marked Be Thomas Morton McMillan Mary Grace Myers 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Baltimore, MD 5938 Montgomery Road; Elkton, Maryland 21075 Rae Force/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify 21. Signature of Funeral Service Licensee

Daniel A. Naylor ²² Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Raltimore, Maryland 21201 alons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complic Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Asphyxia complicated by Dyphenhydramine Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial - trai Physician/Medical UNPENDED AMENDED #10c,19b,perINF,G902,4/19/2010,WS 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.0 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? this certificate l ✔ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 DOA 1 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject took medication and plastic bag ___ Natural **FOUND** neral Director: , filled in by the f 1 Yes 2 ✔ No Pending Mar 11, 2010 1110 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 700 Elm Road, BWI Airport, MD determined (Specify) Airport parking garage To the Funeral Homicide 29a. Certifier 1 completely 24 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

(10)

Ana Rubio MD. As

State 31. Date filed (Month, Day, Year)

Registrar 144 R 2 9 20

Assistant Medical Examiner 111 Penn S

(ear) 32. Registrar's Sinature

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 12, 2010

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68760,	
Box	
P.0	
Records,	
Vital	
of	
Division	

			For State Registrar	State of Maryland		artment of F rtificate of L			rgiene Reg. No. 20	0 09488
ı	Physicia	an	1. Decedent's Name (First, Middle, Last Dongnghi Khank	) Nguyen				2. Date of De Month	Day Yea	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	MARCI	4c. County of De	
أمي	Examin	er	-0 A	SPITAL			MORE		-	
	Funeral Director		5. Social Security Number 6. Se	x 7. Age ( <i>In yrs. l</i> a ☐ M 2 <b>X</b> F 30	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 4/10/	rth 9. E ay, Year) 1979 \	Sirthplace (State or Foreign Country) <b>ietna</b> m
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryla I-f sho	tor	MD Baltimor			nsville				1 □Yes 2 No
	or 28a	Director	10e. Street and Number			10f. Zip Code		,	10g. Citizen of What	Country?
	23a c	ral	900 Kent Avenue	e			228		USA	
036	within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Exercities must be notified as	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  ☐ Yes 2  ▼No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ሺ No	ispanic Origin? (Spanic Origin? (Spanic Origin) Specify:	pecify Yes or No Rican, etc.)	o- 14. Race - Al Black, Wl Specify:	nerican Indian, nite, etc. Asian
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121	filed within Hygiene. <b>yther than</b> "	Idm	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	) -		Pogustry	
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yland	و کا کا و	To B	Khanh Phuoc	Nguyen			Tam Thi	i Ngo		
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χ. Σ	D ± 13 ± G	, y	Tony Triet Minh D				ue; Cator		, MD 21228	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.	0	20a. Method of Disposition  1 🔀 Burial 2 ☐ Cremation 3 ☐ f 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	emetery, crei est La	sition (Name of matory or other plac wn Mem.Ga	rden 3/2		20c. Location - City Marriotts	ville. MD
Rall	permit Depart Import any In	15	21. Signature of Funeral Lio	LIC # M01537	F1	2. Name and Address ineral Hot 530 Edmon	ss of Facility Ste me of Cat dson Ave	rling consvil Cator	Ashton Schu le, Inc. nsville, M	vab Witzke ) 21228
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death ne cause on each line.						Approximate Interval Between
	Physician	î	Immediate Cause (Final disease or condition	a. BRAW.	ANEL	RSYM				Onset and Death
Į	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
	- 25	Jer	Sequentially list conditions, if any, leading to immediate	b Due to (or as a consequ	ence of):					i i
,	ecuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						]
Ď,	ificate be executed g physician and ts the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):					
58/60,	ficate physi s the b	edical		d						
O. Box	ath cert attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 ▼Unknown	23c. If yes, outcome of pregnai 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	☐ Ectopic pregnanc ☐ Other (specify)	y		23d. Date of Month	delivery Day Year
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ō	Phys	: To	1 Yes 2 No '	1 ☐ Inpatient 2 🛣	ER/Outpatie 28b. Time o	" 3 LI DOA	4 LI Nursing H		how injury occurred	pecify)
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DIVISION	al or Atte s after des il Directol ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location ( City or To	(Street and Number or wn, State)	Rural Route Number,
	To the Hospital or Attending Physician: The I within 24 but and the formus after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier (Check only one)  1 ☑ Certifying Phy 2 ☐ Medical Exam	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, deat ion and/or ir	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the rred at the time	e cause(s) and manne , date and place, and	r as stated. due to the cause(s)
	To the comp	ğ	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
	2			al MS			505			2, 2010
	10		30. Name and address of person who of	ompleted cause of death (Item	23a) (Type,	Print) es Hosa	oital. F.	Baltin	nore,	
	Sta Registr		31. Date filed (Month, Day, Year)  NAR 2	ompleted cause of death (Item  32. Registra's Signat  9 2010	ure .	park	,			
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		•	1 - State Registrar Certificate of Death									Reg. No	ZUIL	091	+89
	Physicia	n/	1. Decedent's Name (First, A	iddle, La		/ICK					2. Date of Dea		ay 201 ^V 0 ^{ar}	3. Time of I	Death P _M
~	Medic Examin	al	FRANCES  4a. Facility Name (if not institute)	ıtion, giv				4b. City, Town, o	r Location	of Death	PIAICH	$\overline{}$	. County of Dear		1
			ST. JOSEPH 5. Social Security Number	6.0	20v 7 A	an /In um In	nt histhday)	TOWSON  If Under 1 Year	If I Inde	r 24 Hrs.	B. Date of Birtl		ALTIMOR	thplace (State or	Foreign
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	ind show at	or	Usual Residence of Deceder 10a. State 10b. Co			10c. City	, Town or Lo	cation						10d. Inside City	y Limits
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900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1  Never Married 2    3  Widowed 4  Divi	Married	12. Was Decedent	t Ever in U.S		Was Decedent of H If Yes, specify Cub			fy Yes or No- can, etc.)		14. Race - Ame Black, Whit Specify:		
21215-0036	ithin 72 hou ene. • than "nati he Medica	Completed by		highest g	Education trade completed) College (1-4 or	r 5+)	(Give life. D	dent's Usual Occup kind of work done O NOT use retired, NER	during mo	ost of working  CLOTHING STORE					
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	and 2 sh Health ar <b>em 27 is</b> t <b>ther trau</b>		JAMES NOVI				4713	KESWICK				, MI	21210	)	
Baltimore,	permit. Page 1 at Department of H Important: If itel any injury or ott once,		20a, Method of Disposition 1 ☑ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Of	tion 3	Removal from Sta	te c	emetery, crei	osition (Name of matory or other pla RK CEMETE	RY	3/26/	2010	EME	ocation - City or ERSON, N	IJ	
Bal	permit Depar Impor any in		21. Signature of Funeral Ser	ice Licer	nsee			2. Name and Addre 3900 REIS					& BROS. SVILLE,		80
	Physician/	E	23a. Part 1. Enter the disea shock, or heart failure. Immediate Cause (Final disease or condition	e, or con List only	nplications that caus one cause on each li	ine.		er the mode of dyi	ng, such a	s cardiac or	respiratory arr	rest,		Approximate Interval Betv Onset and D	veen
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ital	vysician: The nis certificate director, pag	8	25. Was case referred to me examiner?  1 Yes 2 No	lical	Hospital:	etiant O	ED/Outpotio	Ot	or:	eath (Check		donno	6 ☐ Other (Spe	264	
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Division	l or Atter after dez Director I in by th	Certificate:		ould not etermined	28e. Place of I	njury - At ho etc. (Specify		reet, factory, office		2	8f. Location (S City or Tow		nd Number or Ru e)	ıral Route Numb	er,
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	•		30. Name and address of pe	rson who	completed cause o	f death (Item		Print)  SLER DR	#2	10 -T	III KAN	1 1	10 2	11204	
	Sta Registr		31. Date filed (Month, Day, )	2010	32. Regis	strar's Signat			710	,0 10	/WWN	; ( V		1	

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Please Type or Print in Black Indebble/Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Montal Hygiene 23aPt1,11,25,27,28a-1 per me, 8901,03/26/2010 and Certificate of Death

State of Maryland / Department of Health and Montal Hygiene Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Julia Ann Placko March 1 3 ay 20⁴10 7:40P Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster 2004812443446 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 X 3/14/1924 PA 85 -220 - 12 - 3476Director Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Westminster Carroll 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2055 Tyrone Rd. items 23a Funeral 21158 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Completed 3 □**X**Vidowed 4 □ Divorced Specify: white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) Clothing College (1-4 or 5+) Presser 12 Be 17. Father's Name (First, Middle, Last) Peter Steve Chovan 18. Mother's Name (First, Middle, Maiden Surname)
Julia Kalincak Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2055 Tyrone Rd., Westminster, MD 21158 Michelle Cutsail-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 
Burial 2 Cremation 3 
Removal from State south Carroll Crem 3/15/10 Winfield, MD 4 Donation 5 Other (Specify) Fletcher Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between B3 Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) LAPROVED BY MEDICAL EXAMINE the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 CERTIFICATI for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Tachycardi Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed Atrial Fibrillation, Hypertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? certificate ☐ Yes 2 ☑ N 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Accident 5 Pending 03/09/2010 Unknown_M Subject tripped and fell Division 2 🔀 No 1 Tes Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Outside Steps 28f. Location (Street and Number or Rural Route Number, City or Town, State Unknown determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) westmenster Rd MD washene ton 31. Date filed (*Month, Day, Year)* **MAR 26 2010** . Registrar's Signature State Barko Registrar

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10-01936 Mildred Phlinda	Din	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene											
ivilidied Fillilida	Γıμ	1- For State Registrar		/ Departmo Certifica			and Me	ental Hy		Reg. No.	201	0 0949	
Physici Medical Exam		MILDKED PHILLING	OA PIPE						Date of De Month March 8	Day	Year	3. Time of Death 1610 hrs	
		4a. Facility Name (if not institution, giv 5033 54th Place	e street and number	)	4	b. City, Town, Hyattsville		n of Death			County of De- ince Geor		
Funeral	Г	Social Security Number     6. Security Number	7. Ag	ge (In yrs. last birti	hday)	If Under 1 Y		nder 24Hrs.	8. Date of E	Birth (MM/D		Birthplace (State or eign	
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w any		10a. State 10b. County		10c. City, Town	or Locatio	าก			·			10d. Inside City Limit	
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2 hours after death with the Maryland "natural", or items 23a or 28a-f show any I Examiner must be notified at once,	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces?		13. Was	Decedent of s, specify Cub	Hispanic O	origin? (Spec	cify Yes or N			erican Indian, Black,	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	19a. Informant's Name/Relationship (T	ype, Print )	19b.	. Mailing .	Address (Str	eet and Nu	umber or Rur	al Route Nu	ımber, City	or Town, Sta	te, Zip Code)	
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Baltimore, permit. Pages I ar Department of Hee important: If ite		1 Burial 2 X Cremation 3	Removal from Sta		ry or othe	er place)			Date			or Town, State	
Baltimo permit. Pag Department Important: injury or ot		21. Signature of Funeral Service Licensee  22. Name and Address of Facility TAMES A. MORTON & SONS R H. TN											
		JAMES A. MORTON & SONS F.H., IN  1701-31 LAURENS ST. BALTIMORE, MD 21217											
Physician /Medical		Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interventional Entervention of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart between Onset and Service of Conset a											
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		29a. Certifier (Check only Certifying Physicia	n: To the best of my	knowledge, death	occurre	d at the time, o	date and pl	ace, and due	to the caus	se(s) and n	nanner as stat	ted.	
To the How within 24 h To the Fun	Medical	one) 2 Medical Examiner: 29b. Signature and title of certifier	On the basis of exame and manner stated.	nination and/or inv	estigation		n, death o		e time, date				
		11/11/	V. V. To	. )			.M.E.	OGME			9, 2010	onth, Day, Year)	
1 /		30. Name and address of person who co				11 D== 0	tunct D	ш	ID 0425				
Sta	ite	Theodore M. King, Jr., MD.		s Signature	er 1	11 Penn S	treet, Ba	aitimore, N	/IU 21201	1		·	
Regist		MAR 29 2	UIO Sens	un B.	100	Lead							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 23 Year ZOIC 1109PM Ida Patterson Mar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, 2-28-1 🗆 M 2 🗶 F Days Hours Min Months - 19<u>35</u> **Director** Yrs ٧A <u>212-34-2238</u> Usual Residence of Decedent 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MΠ na Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 501 E. Preston Street USA items ? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours aftr ment of Health and Mental Hygiene. ant. If item 27 Is marked other than "natural", ury or other traumatic event, the Medical Exau ury or other traumatic event, the Medical 1 ☐ Yes 2XXNo Specify: Black Specify: Completed 3 😾 Widowed 4 🗆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th grade College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ Ida Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fredia Patterson-Daughter 2307 Whitter Avenue Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State cemetery, crematory or other place)
Mt Carmel Cem Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4-2-2010 Balto, MD 21. Signature of Funeral Service Licenses lame and Address of Facility MARCH EA 1101 E. North Avenue F/H Balto,MD 21202 22. Name and Address of Facility EAST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death e Physician/ PTIC disease or condition dais Medical resulting in death) Due to (or as a consequence of) Examiner URINARY 0 days Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed bunial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 4 Pregnant a 9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death sate has been signed by the a page 2 should be detached it 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate ☐ Yes 2 ☐ No Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

only one) 29b. Signature and title of certifi-

am

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Yown - Unm Memorual

To the lawithin 2

Hospital.

29d. Date signed (Month, Day, Year)

Mar 23, 2010

21215

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Dohn

Kollarathil 9000 FRANKLIN SQUEE Dr. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gensun

**ORIGINAL** 

Balto md 21237

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

cente Perez-S	oto	1- For State Certificate of Death 2010 0949													
Physicia	an/	1. Decedent's Name (First, Middle,L	_ast)						2	2. Date of D	eath			3. Time of Death	-
edical Exami		Vicente Perez S	<del>oto</del> Vicer	ite P	erez So					Month March 1	0, 201	0 Year		0418 hrs	
		4a. Facility Name (if not institution,	give street and number)			b. City, To		ocation of	Death			c. County of			
		10834 Williamson Lane		// In	- ( Link dou)	Cockey		if I ladar	240-0	To Data of		Baltimore		-	
Funeral Director		5. Social Security Number unl 6.	1	-	ast birthday)	If Under Months	1 Year Days	If Under Hours		8. Date of pril	1/1		Foreign	hplace (State on 17)	Ĉ
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kut		10a. State 10b. County		10c. City,	Town or Locatio	n								10d. Inside City Limit	s
id how s	_	MD Balti	- 1		ckeysvil									1 Yes 2 N	
arylan 8a-f s	Director	10e. Street and Number			1	10f. Zip C	ode				10g. Ci	itizen of Wha	it Coun	try? <del>unk</del>	_
the M. a or 2	Dire	10834 Williamso	n Lane			21	030				Mex	ico			
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death or iter	Funeral	1 X Never Married 2 Marri		X No	IT Yes	s, specify	Cuban, n	vlexican, r	Puerto K	ican, etc.)		White W			
after	by F		ced If Yes, Give Year			Yes 2	_		Mexi			Specify: 1			
hours	ted	15. Decedent's Education (Specify	only highest grade comp College (1-4 or 5		16a. Decedent's during mos						1K 16b.	Kind of Bus	ness/Ir	ndustry WTTK	
36 nin 72 E. than	aldi	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Const	ructi	on				l _R	oof Co	mna	nv	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be (	Dionicio Perez					M	Maric	arme	n Sot	0				
21 nould in Mer is mail	70	19a. Informant's Name/Relationship			19b. Mailing		(Street a	and Numbe	er or Ru	ral Route N	umber, (				_
Baltimore, MD 21215-0036  Peprint. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		O.C.M.E. Nazaria	Perez Soto/S	ister	Avenue	DE 1	<b>SFEE</b>	ŏ #8	B Do	m°šėl	ast	ian.	uān	20⊥ ājūato,	
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Page ment of		4 Deserting 5-38-00	v in atata	Nue Do I	stra Se	nora	De 1	Los	4/16	6/2010		_	-	ral Servic	
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Physician /Medical		failure. List only one cause on	each line.		Do not enter the	) mode or v	Jyiriy, su	JCII as can	nac or i	espiratory c	afrest, si	10CK, UI⊓ <del>o</del> ai	<b>'</b>	Approximate Interva Between Onset and Death	
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Division Hospital or Attendit 24 hours after death. Funeral Director: A	Certification:	3 Suicide 6 Could no determin		-		factory, or	ffice build	ding, etc.		or Town,	State)			al Route Number, City	'
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	Me	29b. Signature and title of certifier	and manner stated.			29c. L	icense n	number			29d.	Date signed	(Mont	h, Day, Year)	-
		Jahrel Fruith	all MA				D.C.M.	E.			Ma	rch 11, 20	010		
	1	30. Name and address of person who	o completed cause of de	ath (Item 2	23a)										
4	-	Pamela E. Southall, MD				Penn S	treet, F	3altimo	re, MD	21201					23
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	barker	7									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Paul Retz 21:29DM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner AGNES MOSPITAL BALTIMOR 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral X**XM 2□ F Months Days Hours 212-32-6340 UNK June 19,1935 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene.

n 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exampler must be notified at Baltimore Pikesville 1 ☐ Yes 2 X No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 7920 Scotts Level USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status UNK 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □ Yes 2/CNNo Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNK UNK UNK UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK UNK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. Holloway And Sullivan 10 N. Calvert St.Baltimore, MD, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Baltimore, MD 3/24/10 Mt.Carmel Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 2829 Hudson Street Teara Skarda F.H. Baltimore, MD. 21224 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Severe Immediate Cause (Final **Physician** Trup of disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ECHOO MU Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown signed by the of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DURGADMOT ADHIKARI 03/15/2010 23612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADHIKARI, 900 (aton Avenue, Baltimore, MD212) DURGA DHQT

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Marion L. Rose 32010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore Genesis Loch Raven | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 02-14-1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 🗹 F Maryland 217-18-9004 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Parkville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 7807 01d Harford Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa M. Schohn John J. Kaufmann 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7805 Old Harford Road Baltimore, Maryland 21234 Katherine Davidson - Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 03-29-2010 Holy Cross Cemetery Glen Burnie, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or co-plir ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only the cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ones a consequence of) Examine death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed? this certificate 1☐ Yes 2☑No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 To the mosp...
within 24 hours after deatn.
To the Funeral Director: After th funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☑ Natural 2 ☐ Accident Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760 Division or Vital Records,

To the Hospital

29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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29d. Date signed (Month, Day, Year)

1/ A Rockulle MD 20850

use of das th (Item 23a) (Type, Print) 30. Name and address of person who completed ca 0

31. Date filed (Month, Day,

egistrar's Signature

Medical

eray

		State Registrar		C	ertificate of	Death		Mental Hygiene Reg. No. 2010 0949			
sicia	n	1. Decedent's Name (First, Middle, Last) Pamela Rosenberry					2. Date of Death	e of Death th Day Year 3. Time of Death Pruary 24, 2010 9:45 AM			
edica mine		4a. Facility Name (If not institution, give str			4b. City. Town.	or Location of Deat		4c. County of Dea			
mme		2278 Baldwin Mil				llston		Harfor			
ral lor		210-40-2329	7. Ag	e (In yrs. last birthda 62 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 1948 Man	rthplace (State or Forei ountry) 'yland		
	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limit		
	į į	MD Harford		Fallst	on				1 □ Yes 2√ N		
00000	5	10e. Street and Number 2278 Baldwin Mill	Road		10f. Zip Code	21047	10	og. Citizen of What C USA	ountry?		
	Funeral				B. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S	Specify Yes or No-	14. Race - Am			
1		1 ☐ Never Married 2 X Married	If Yes Give **				to Alcan, etc.)	Black, White, etc.  Specify: white			
	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educat	Year or Dates:	16a De	1 □ Yes 2 💢 No cedent's Usual Occu			16b. Kind of Business/Industry			
	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4or 5	(Gi	ve kind of work done  DO NOT use retire	during most of wo	rking	TOD. KING OF BUSINESS	unk		
	Ę.	12	0	· I	home care	giver					
ď	e P	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	faiden Surname)			
Ė	≗ .	Conrad Werner S					r Geraldi				
		19a. Informant's Name/Relationship (Type Larry Rosenberry/s		l l	iling Address <i>(Stree</i> : 8 Baldwin			City or Town, State,	2ip Code) .047		
	1	20a. Method of Disposition	F	20b. Place of Dis	position (Name of			20c. Location - City or			
		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☑ Donation 5 ☐ Other (Specify)	noval from State	cemetery, ci	ematory`or other pla	ice)					
NIINE.		21. Signature of Evneral Service Licensee Paniel A. Na	ylo			-		Baltimore	Street		
		23a. Part 1. Enter the disease, or complica	tions that caused	the death. Do not e	Baltimore, enter the mode of dy			est,	Approximate		
	1	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Juniors Cell Ce of Exillary Sins Sins Sins Sins Sins Sins Sins Sins									
1		resulting in death)	ue to (or as	a consequence of):	7	ð	31-1-5		77777		
1	_	Sequentially list conditions. b.									
		Sequentially list conditions, list years and list conditions, list years and list cause. Enter Underlying Cause (Disease or injury	Due to Lor as	a consequence of):							
	Examiner	that initiated events resulting in death) Last   Due to (or as a consequence of):									
		d.									
3	led	IF FEMALE:							-		
	Pnysician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	B	су		23d. Date of de Month	Day Year		
1	٢	9 Unknown		1 20 200							
1	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  ASHAMA					23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow				
	Сощріете	13 4									
	ā. E	1+124					24a. Was ar autopsy perform	y prior to	utopsy findings availal completion of cause of		
	00	25. Was case referred to medical					1 ☐ Yes 2	1 □Ye	s 2□No		
10	ן מ	examiner?	pital: 1 □ Innatie	ent 2 ☐ ER/Outpat	ient 3 🗆 DOA Ott	hor:	ath (Check only one	nce 6 ⊠rŐther <i>(Sp</i>	noity if E		
l i	0	27. Manner of Death	28a. Date of Inju	ry 28b. Time			28d. Describe ho		ecily) 95		
	9110	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 1 Accident investigation 28c. Injury at Work? 1 Yes 2 No									
1	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Richt of Town, State)						Rural Route Number,			
	edicai	29a. Certifier  (Check only one)    Check only one of examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
NA.		29b. Signature and title of certifier			29c. Licen	29c. License number			29d. Date signed (Month, Day, Year)		
		Wand Kler mo			D	3 ,					
	-	Wind Kley MO  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Wenck Klosesz 5701 Kennas d Due Bout no 21206							-		
				convoid r	our Bou	t mo	21206				
	_ ]	31. Date filed Month, Day, Year)		ar's Signature							

			- State Amend Item 23aP	te of Maryland /	Departme le , g 90 I , 0. Certifica	3/26/2010 te of Deat	<b>)dhb</b> <i>h</i>	tai Hygie Reg.	ne no2 ()   ()	09498	
	Physicia	1. Decedent's Name (First, Middle, Last)  Alvina Teresa Smith							Day Year 28 2010	3. Time of Death	
man line	/Medic Examin		4a. Facility Name (If not institution, give street a	on of Death							
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2/2	7. Age (In yrs. last		r 1 Year   If Und	ler 24 Hrs. 8. D	Date of Birth Month, Day, Ye n. 11,	ear) 9. Birthp Coun 1927 Mar	lace (State or Foreign try) yland	
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location				11	Od. Inside City Limits	
	Maryl	tor	MD Baltimore		Parkvi.	lle				1 ☐ Yes 2 💢 No	
	or 28	Director	10e. Street and Number		10f. Z	p Code		10g.	Citizen of What Coun	try?	
	s 23a	Funeral	9133 Covered Bridge	Road s Decedent Ever in U.S.	13 Was Door	21234	Origin? (Specify.)	Ves or No.	U.S.A.	an Indian	
5-0036 72 hours after death with the Maryland inatural", or items 23a or 28a-f show dien Evan in a court be notified at	urs after de al", or item Evanimen	þ	1 □ Never Married 2 M Married 1 □ If Y	ned Forces?  ]Yes 2 7 No es, Give ar or Dates:	If Yes, spi	edent of Hispanic ( ecify Cuban, Mexic 2 XNo Speci		n, etc.)	Black, White, e	etc.	
21215-0036	72 ho 'natur	etec	15. Decedent's Education (Specify only highest grade comp		6a. Decedent's Us (Give kind of w	ual Occupation ork done during m use retired)	nost of working	166	. Kind of Business/Ind	lustry	
121	filed within Hygiene. other than '	Completed	Elementary/Secondary (0-12) Col	liege (1-4or 5+)	Homen				At Home		
more, Maryland ages 1 and 2 should be file ent of Heatth and Mental Hy it: if item 27 Is marked oth y or other traumatic event	To Be C	17. Father's Name (First, Middle, Last)  James Andrysiak				other's Name (First Da Jaworsk		den Surname)			
	and 2 shousatth and Iv	_	19a. Informant's Name/Relationship (Type. Prin Ralph Smith/Husban	′				Road, Pa	ity or Town, State, Zip arkville,	MD 21234	
	Pages 1 ament of He ant: If item		20a. Method of Disposition  1	from State 20b. Place ceme	e of Disposition (Na etery, crematory or Stanis	other place) Laus	0 3/04 / 2	2010 Di	Location - City or To	yland	
Balt	permit. F Departm Importar any injur		21. Signature of Funeral Service Licensee	Eichs	10000	Harror	u koad,	Parkv	remation Ser ille, MD 212	34	
	Dhysieian		a. Part 1. Enter the disease, or complications stock, or hear failure. List only one cause Imm diate Cause (Final)	se on each line.				spiratory arrest		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	ice of):	ilae accident.						
	Examiner	L	Sequentially list conditions, if any, leading to immediate	Hyperter	ision,	Abri	al fil	stille	atton:		
ted 1sit	nsit	Examiner	Cause (Disease or injury	b. Hypertension, Atrial fibrillation:  Due to (or as a consequence of):  c. Aspiration Preumonia							
68760, ificate be executed g physician and as the burial-transit		ledical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):				ATION APPROVED BY MEDICAL EXAMINER			
89		Medi	IF FEMALE:				CERTIFICATION	2110 -		<u> </u>	
O. Box	or Attending Physician: The law requires that the death certificate death.  Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnancy ☐ Live birth 2 ☐ Fetal de ☐ Pregnant at time of deat ☐ Unknown	eath 3 🗆 Ectopic				23d. Date of delive Month	ery Day Year	
٠ <u>٠</u>	uires that the de signed by the a d be detached t	by Ph	Part II. Other significant conditions contribution	ng to death but not resultin	ng in the underlying	cause given in Pa	ırt I.	23e. Did tobac	cco use contribute to the	ne cause of death?	
rds	w requires been sig should be	ed b	DIVERTICULO	515,1	LUNG C	ANCE	<u>R</u> ,	1 🗆 Yes	2 No 3 Prot	ably 4 🗆 Unknown	
Division of Vital Records,	Physician: The law re r this certificate has be ral director, page 2 sh	Completed	RECURRENT	CAUS	•	<u>,, , , , , , , , , , , , , , , , , , ,</u>		24a. Was an autopsy performed 1 □Yes 2 ☐	d? prior to co death?	psy findings available mpletion of cause of	
Z Z	siclan certifi rector,	Be	25. Was case referred to medical examiner?  Yes 22100  Hospita	li . EC	NO	Othor:	ace of Death (Ct		0.000		
o	ding Phys h. After this funeral di	n: To	27. Manyrer of Death 28a	i. Date of Injury 28	Bb. Time of	28c. Injury at Work?		Describe how	e 6 Other (Special of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	<u>y)</u>	
Ö	tending leath. tor: Aft the fun	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury M	1 ☐ Yes 2	□No				
Divis	pital or Attenous after deatlers after deatleral Director:	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Y 2 4 5 2 0 0 (Check only 2								nd place, and due to the cause(s) and manner as stated.  ath occurred at the time, date and place, and due to the cause(s)			
/	To the within 2 To the соптріе	Me	29b. Signature and title of certifier			9c. License numbe	er	29d	. Date signed (Month,	Day, Year)	
3			) Doll	PUYI IN.	TERN	RES	000	M	larch 2	2010	
	181		30. Name and address of person who complete	MEDICAL	- INTE	RN, C	1000 5	AMAF	SITANTO	SP. BA UTIN	
	Sta		31. Date filed (Month, Day, Year)	32. Registry's Signatur					'n		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Kathryn Harding Stunkle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner IMPORE Baltimore
9. Birthplace (State or Foreign 5. Social Security Number If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 08/12/1920 7. Age (In yrs. last birthday **Funeral** Months Hours Country) 1 ☐ M 2 🔀 F 228-26-8847 Director 89 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. Intel it is a state of the than "natural", or items 23a or 28a-f show mit: If item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, I'm Medical Expriniter mast be rectlifted at my or other traumatic event, I'm Medical Expriniter mast be rectlifted at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f shout the Medical Examiner must be notified at Howard Ellicott City 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 5114 Crystal Park Lane 21043 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ģ Specify. Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Harding Pauline Harding ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. 5114 Crystal Park Lane, Ellicott, City, MD 21043 Susan S. Maloney, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Gremation Services 03/29/2010 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Argent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): 68760 physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' certificate Vital 1 □Yes 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Impatient of this within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral or 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 □ Yes 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29b. Signature a 29d. Date signed (Month. Dav. Year)

Registrar

30. Name and address of person who completed cause of de

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month orence 12:45AM 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bultimore N/A 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 0 M 2 1 F 9/3/35 217-66-4959 Director VA Usual Residence of Decedent or 28a-f shov 10b. County 10a. State with the Maryland items 23a or 28a-f sho her must be notified at 10c. City, Town or Location Randlestown 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 8507 Allenwood Road USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iter edical Examiner Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐MNo Specify: s American Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Birth Disable other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Madison E. Smith, Sr. Bessie B. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madison E. Smith, Jr. / Brother 8507 Allenwood Rd, Balt. County, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date injury or 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Arbutus, MD 4/3/10 Arbutus Mem. 4 Donation 5 Other (Opecify) 21. Signature of Filheral Service Lice 22. Name and Address of Facility Hari P. Close F. Svs.PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner andlowsculgs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami burial-transi certificate be executed and Due to (or as a consequence of): inding physician a use as the burial-Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown , the ; 9 Unknown P.O. eate nas been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🔁 No 1 Inpatient 2 ER/Outpatient 3 DOA 4.2 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 🔀 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated March 29 2016 moton

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur